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No.____

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1987

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE VALLEY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DISTRICT DENTAL SOCIETY; YORK COUNTY DENTAL SOCIETY; FIFTH DISTRICT DENTAL SOCIETY; DENNIS W. KING, D.D.S.; CHARLES M. LUDWIG, D.D.S.; THEODORE R. PALADINO, D.D.S.; THOMAS L. PERKINS, D.M.D.; and KAY F. THOMPSON, D.D.S.,
Petitioners

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED

1. Whether legitimate petitioning activity under the first amendment of the United States Constitution loses its immunity from the Sherman Act simply because it is accompanied by other conduct which is not direct petitioning activity?

2. Whether, under the rule of reason, summary judgment can be reversed on Sherman Act Section One claims based on presumptions of anticompetitive effects where there is no supporting evidence?

3. Whether, consistent with due process of law, an appeals court may reverse summary judgment, in violation of its own law of the case and the preclusionary orders of a trial court, without any proper evidence to support the reversal, and in disregard of constitutional defenses clearly articulated to it?

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Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

The Pennsylvania Dental Association, nine other dental societies in Pennsylvania, and five individual dentists ("Dentists") petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.[1]

1. The names of all parties in the proceeding below are indicated in the caption of the case in this Court. Respondent, Medical Service Association of Pennsylvania, d/b/a Pennsylvania Blue Shield, is referred to herein as "Blue Shield." Pursuant to Rule 28.1, it is hereby stated that there are no parent companies, subsidiaries, or affiliates of any of the corporate Petitioners.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit is reported at 815 F.2d 270, and is reprinted as Appendix A. The judgment of the Court of Appeals denying the petition for rehearing *en banc* is reprinted as Appendix C. The opinion of the United States District Court for the Middle District of Pennsylvania is reported at 632 F.Supp. 653 and is reprinted as Appendix B.

Because this petition for a writ of certiorari involves, in part, a fundamentally unfair failure of the Court of Appeals to apply consistent standards and rules of law, previous opinions of the Court of Appeals and District Court also are attached, as Appendix D and Appendix E, respectively.

JURISDICTION

The opinion and order sought to be reviewed was entered by the United States Court of Appeals for the Third Circuit on March 30, 1987. A timely petition for rehearing *en banc* was denied by the Court of Appeals on April 23, 1987. The jurisdiction of this Honorable Court is invoked pursuant to 28 U.S.C. §1254(1).

CONSTITUTIONAL PROVISIONS, STATUTES, AND RULES

This case involves petitioning under the first amendment, an alleged conspiracy under Section One of the Sherman Act, and claims for damages and injunctive relief under Sections Four and Sixteen of the Clayton Act. The Third Circuit's decision involves all of these provisions, and also raises serious due process and Fed.R.Civ.P. 56 questions. All of the pertinent provisions are reprinted in Appendix G.

STATEMENT OF THE CASE

1. Background

Petitioners seek a review of the decision of the United States Court of Appeals for the Third Circuit. That Court

reversed in its entirety the decision of the United States District Court that granted summary judgment in favor of the Dentists against the claims of Blue Shield. Blue Shield had alleged, *inter alia*, that the Dentists had violated Section One of the Sherman Act, 15 U.S.C. §1, by petitioning the Pennsylvania legislature and participating in various judicial and administrative proceedings "where dentists expressed their grievances." (Blue Shield Br. of 9/2/86, at 19; J.A. at 344 ¶27j.)

A principal issue raised by the Dentists was the participating dentist system established by Blue Shield's "Participating Doctor Agreements."[2] Besides the Dentists' petitioning activities, Blue Shield alleged that, in 1974 and 1975, Pennsylvania dentists through their professional associations passed resolutions encouraging dentists not to sign these Agreements.

Blue Shield claims that as a result of the Dentists' activities its patients have been hampered in their ability to receive discounted services from participating dentists. Blue Shield then argues that this has hurt its ability to market its dental programs in Pennsylvania, and consequently seeks over seventeen million dollars in damages.

Despite these allegations, Blue Shield's Vice President of Sales flatly admitted in discovery that not one Blue Shield sale was lost due to an insufficient number of participating dentists.

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2. Briefly, the Blue Shield participating dentist system works as follows: Blue Shield signs dentists to "Participating Doctor Agreements," pursuant to which the dentists agree to perform a variety of services in return for direct payment from Blue Shield based on a formulated fee schedule. (Pet.App. 76a-77a.) Blue Shield then markets its dental programs to group purchasers in Pennsylvania, such as large businesses and government entities.

From the perspective of patients insured under the programs, if they use the services of a participating dentist, they will be assured of incurring no out-of-pocket expense since the participating dentist is contractually bound to accept Blue Shield's payment as payment-in-full. On the other hand, if the patients use the services of a non-participating dentist, Blue Shield will still make the formula payment, but the dentist has the discretion to decide to bill the patient for any difference between the dentist's charge and Blue Shield's payment. Notwithstanding this seeming distinction, in the majority of instances Blue Shield's formula allowances equal the dentists' current charges, and the patient is not affected financially by going to a non-participating dentist. (J.A. 3490 ¶14; 3497 ¶42; 3541-42.)

(J.A. 3593-94.) Moreover, over six years after Blue Shield levelled the above allegations and after extensive discovery, Blue Shield has been unable to produce even one patient who says he could not receive the "discounted" services of a participating dentist. In fact, Blue Shield's former president admitted in his deposition that there was no such instance. (J.A. 3595-97.)

2. Proceedings Below

Blue Shield's case is the last vestige of what the Third Circuit had previously described as an "ill-fated" antitrust case originally brought by the Commonwealth of Pennsylvania over five years ago. See *Pennsylvania Dental Ass'n v. Medical Service Ass'n*, 745 F.2d 248, 252 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985) (Pet.App. 72a.). A brief review of the proceedings below is necessary in order to see the case in proper context and to understand the fundamental errors made by the Court of Appeals.

Approximately seven years ago, some Pennsylvania dentists were petitioning the Pennsylvania legislature seeking to amend Blue Shield's regulatory act[3] in ways which Blue Shield thought objectionable. (J.A. 5116-5150.) Additionally, the Dentists were involved in various judicial and administrative proceedings with Blue Shield which eventually would clarify the respective rights of dentists, Blue Shield, and patients participating in Blue Shield dental plans. (J.A. 4801-4858; 5010-63; 5580-5609; 8361.)

Apparently in retaliation for this petitioning, Blue Shield's then Vice-President of Dental Affairs contacted Pennsylvania's Office of Attorney General. (Waye Depo. of 12/22/81, at pp. 26-30.) On the basis of information then provided, the Commonwealth of Pennsylvania filed an antitrust complaint against most of the Dentists now before the Court. (J.A. 81-96.) Essentially, the Commonwealth alleged that the Dentists had passed resolutions in 1974 and 1975 which urged nonparticipation in Blue Shield's dental programs. (J.A. 91-92.) After extensive discovery, the Commonwealth dismissed its case. (J.A. 882-921; 942-82.)

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3. 40 Pa.C.S. §§6301 *et seq.*

In the meantime, the Dentists had brought Blue Shield formally into the suit. The Dentists alleged that Blue Shield and others were engaged in illegal price-fixing and boycott conspiracies, and that Blue Shield was monopolizing certain dental markets in Pennsylvania. (J.A. 1360-88.)

Blue Shield answered, and counterclaimed against the Dentists. The counterclaim was a "mirror image" of the Complaint which the Commonwealth voluntarily withdrew, with a few additional allegations. (*Compare* J.A. 91-92 *with* J.A. 342-45.)

After years of discovery, the District Court entered a scheduling order, pursuant to which the parties were to submit preclusive pretrial memoranda that listed, *inter alia*, all facts to be proven and all witnesses to testify at trial. (J.A. 2435-42.) The parties filed their preclusive pretrial memoranda, and Blue Shield did not list any witnesses to testify to its alleged lost sales injury.[4] (J.A. 3318-47.)

a. Blue Shield's Summary Judgment Motion: Blue Shield then filed a motion for summary judgment with respect to the Dentists' antitrust claims against it. This motion is significant, because it led to the law of the case being established on key points of Blue Shield's affirmative case against the Dentists. Specifically, Blue Shield argued in its motion and supporting papers that:

> (a) Blue Shield's payment mechanism and system of participating dentists had no appreciable impact on individual dentists' prices for dental services. (J.A. 3940 ¶14; 3947 ¶42; 3503 ¶69); and
>
> (b) Blue Shield's payment mechanism and system of participating dentists were of no significance to purchasers of dental programs in selecting which program to buy (J.A. 3522-23).

These contentions were explicitly accepted by the District Court, which granted Blue Shield's motion. (Pet.App. 104a,

4. Blue Shield did list experts to testify, but only as to amount of damages based upon assumptions which were without record support. (J.A. 3586-88.)

note 11; 105a-106a; and 117a.) The Court of Appeals affirmed, and then this Court denied certiorari. *See Pennsylvania Dental Ass'n v. Medical Service Ass'n*, 574 F.Supp. 457 (M.D.Pa. 1983), *aff'd*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985).

b. The Dentists' Motion: The Dentists filed their Motion for Summary Judgment, based in large part on the fact that Blue Shield's prior assertions in the case, and the courts' acceptance of those assertions, rendered Blue Shield's affirmative claims against the Dentists illogical. Moreover, after studying Blue Shield's preclusive pretrial memorandum, the Dentists found there were no witnesses showing that Blue Shield had suffered any injury resulting from the activities alleged. (J.A. 3321-3347.)

After careful consideration, the District Court granted summary judgment and dismissed Blue Shield's entire case. In doing so, the District Court specifically addressed Blue Shield's allegations that the Dentists' petitioning activities were sham activities that were not protected by the well-established *Noerr-Pennington* exemption from the antitrust laws for legitimate petitioning. (Pet.App. 59a-61a.)[5] The Court concluded that Blue Shield's assertion was "not supported by *any* facts or law." (Pet.App. 61a) (emphasis added).

The District Court also repeatedly applied this Court's holding in *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 106 S.Ct. 1348 (1986), to refrain from making inferences which made no sense in light of Blue Shield's previous assertions and the prior holdings in the case. For example, when confronted with Blue Shield's claim that the Dentists' resolutions questioning dentist participation in insurance programs had caused Blue Shield patients to lose the benefit of its formula "discounts," the District Court recalled Blue Shield's prior assertions that its particular participation system did not affect the prices dentists could charge, and applied *Matsushita* to reject the requested finding:

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5. *United Mine Workers of America v. Pennington*, 381 U.S. 657 (1965); *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961). See Discussion in Point 1, *infra*.

> Herein, [Blue Shield alleges that] the Dentists refused to contract with it at discount prices. . . . This [allegation] is based upon a view of the facts of this case which has no support in the record. We have already rejected the dentists' contention that Blue Shield's reimbursement mechanism sets prices. . . . [The rejection of this contention] require[s] the inference that there is no inherent tendency of the participating dentist system to discount dental prices. . . . [T]here is no other evidence before us which reasonably supports the inference that the dentists' and associations' resolutions . . . had an anticompetitive effect.

(Pet.App. 56a.)[6]

c. The Dentists' Motion on Appeal: In reversing the District Court, the Court of Appeals cavalierly dismissed all constitutional considerations as to whether the Dentists' petitioning activities were immune. The Court stated in one sentence that the activities were not protected because they were "minor" in comparison to activities which were not direct petitioning. (Pet.App. 16a.) Such a quantitative test has never been applied by this Court. Moreover, given the seminal case of *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961), and its progeny, such a test should not be permitted to stand.

Also, the Court of Appeals refused to apply the *Matsushita* proscription against drawing implausible inferences, by narrowly reading that decision to be a prohibition against drawing implausible inferences only *of conspiracy*. (Pet.App. 5a.) The Court of Appeals then overruled 70 years of rule of reason precedents, by egregiously misapplying the holding of *Federal Trade Commission v. Indiana Federation of Dentists*, 106 S.Ct. 2009 (1986), to presume anticompetitive effects without any

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6. The District Court might also have noted at this point that Blue Shield was unable to produce the testimony *of one single patient* who indicated that he was unable to obtain the infrequent participating dentist "discount" when desired.

record support whatsoever. (Pet.App. 10a-11a.) *Indiana Federation* cannot and should not be read in this manner. Notably, in *Indiana Federation*, the agreements to withhold x-rays resulted in the complete elimination of x-rays in at least some local markets, 106 S.Ct. at 2014 and 2017. Here, there is *absolutely not one shred of evidence that a consumer was ever denied the services of a participating dentist when desired.*

Besides misreading *Matsushita* and *Indiana Federation*, the Court of Appeals disregarded the law of the case in permitting Blue Shield to attempt to show that it was injured as a result of the reduction in the statewide percentage of participating dentists. Specifically, the Court ignored its previous finding that the existence of participating dentists is of no consequence to purchasers of prepaid dental programs. Beyond this, the "evidence" which the Court considered to support the impermissible theory that purchasers *do* care about the level of dental participation were affidavits from purchasers (a) who contradicted their *other* affidavits in the case, which were used by Blue Shield to show that the existence of participating dentists did *not* matter, and (b) who were *not* listed and cannot participate as trial witnesses to support Blue Shield's Counterclaim.

REASONS FOR GRANTING THE WRIT

Interlocutory review in this case is necessary because the issues raised by the Court of Appeals' opinion are fundamental to the further conduct of the case and of great public policy importance. *See, e.g., Catalano, Inc. v. Target Stores, Inc.*, 446 U.S. 643, 643-44 (1980); *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 725-27 (1975); *Gillespie v. United States Steel Corp.*, 379 U.S. 148, 153-54 (1964).

Specifically, the Third Circuit decision should be immediately reviewed to correct the unprecedented quantitative test it has created to determine whether direct petitioning activity is immune from antitrust scrutiny. In effect, the Court has held that where challenged conduct which is not direct petitioning

exceeds legitimate direct petitioning, the petitioning somehow loses its immunity. (Argument 1.)

Moreover, the decision unduly limits the *Matsushita* admonition against making unreasonable inferences, and significantly broadens this Court's actual holding in *Indiana Federation* to the point where courts will be required to presume anticompetitive effects for any joint action where even the least bit of economic impact is hypothetically involved. Requiring such presumptions in antitrust cases, where economic considerations and effects can almost always be hypothesized, will overrule this Court's precedents and destroy the effective use of summary judgment in those cases. (Argument 2.)

Additionally, in finding fact of injury, the Third Circuit decision undercuts the effectiveness of the pretrial management techniques of federal trial judges to manage and control complex antitrust cases. Unlike the District Court, the Court of Appeals disregarded the law of the case and the preclusive pretrial memoranda filed by the parties, in order to consider a theory of injury set forth by an expert not listed and who will not testify as a witness. Moreover, the non-expert affiants upon whom the Court relied were also not listed and will not testify as witnesses and had previously submitted affidavits contradicting the ones relied on by the Court of Appeals. Beyond this, the expert affidavit based its conclusion on factual assumptions which are false or unsupported by the record. For these reasons, the Third Circuit's decision should be reviewed immediately, because it will thwart the proper use of the summary judgment procedure in private antitrust cases where the asserted antitrust injury cannot be established or reasonably inferred from the theories and record properly before the federal trial court. (Argument 3, Points A through D.)

The Court of Appeals also (a) reversed on issues neither appealed nor argued in the briefs; (b) never mentioned anything about many of the individual defendants, yet sent them all back to face a long and expensive antitrust trial; and (c) blatantly mischaracterized important constitutional arguments made by the Dentists. Taken either separately or together, this conduct was so fundamentally unfair that the Dentists have been denied

due process of law. This Court should grant immediate review to assure that the constitutional rights of the 6,500 Pennsylvania dentists composing the professional associations in this case are vindicated. (Argument 3, Points E through H.)

1. Certiorari Should Be Granted To Correct the Unprecedented Quantitative Test Established by the Third Circuit for Determining Whether Direct Petitioning Is Immune from Sherman Act Prosecution.

The Third Circuit has established a new and erroneous rule, which would stifle admittedly legitimate petitioning if accompanied by arguably anticompetitive conduct. Immediate review is extremely important in this sensitive area, if first amendment protections normally afforded petitioning are to retain any force.

The Dentists' challenged conduct includes direct legislative, judicial, and administrative petitioning activity. Two examples illustrate this. First, the Dentists' legislative efforts before the Consumer Affairs Committee of the Pennsylvania House of Representatives (J.A. 5116-5150) led to the introduction of bills to amend the act governing Blue Shield. (J.A. 5580-5609.) These bills were adopted as amended by the House of Representatives. Second, in response to the Dentists' written comments regarding the implementation of an alternative delivery system dental plan by Blue Shield, the Pennsylvania Department of Health required Blue Shield to submit periodic reports to ensure quality of care. (J.A. 8361.) (*See also* J.A. 5010-63.)

Such petitioning is clearly protected under the first amendment, as consistently held in a long line of cases starting with *Noerr*.[7] Indeed, in *Noerr*, the challenged activities were wide-

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7. 365 U.S. 127 (1961). *See, e.g., United Mine Workers of America v. Pennington*, 381 U.S. 657, 669-70 (1965) (influencing governmental officials in non-legislative capacity immune) *and California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 510 (1972) (recognizing right of access to courts as "one aspect" of right to petition). *See also NAACP v. Claiborne Hardware Co.*, 458 U.S. 886-87 (1982); *Missouri v. National Organization for Women*, 620 F.2d 1301, 1304-1316 (8th Cir.), *cert. denied*, 449 U.S. 942 (1980).

ranging ones by Pennsylvania businessmen which were otherwise anticompetitive, but which were immune because they involved joint efforts to influence the passage of legislation. And in *Pennington*, the Court extended the *Noerr* immunity to activities designed to influence public officials acting in a non-legislative capacity. 381 U.S. at 669-70.

As noted earlier, the District Court specifically analyzed Blue Shield's claims that the Dentists' petitioning was not exempt under the *Noerr-Pennington* doctrine because it allegedly was "sham." The Court rejected this assertion, finding that it was "not supported by any facts or law." (Pet.App. 61a).

In its principal brief to the Third Circuit, Blue Shield did not even list the District Court's decision on the petitioning activities as an issue, nor did it argue the point. Instead, Blue Shield only mentioned in passing some of the Dentists' legislative, judicial, and administrative petitioning in its Statement of Facts. (Blue Shield Br., at 16, 19-20.) For example, in hardly a bruising challenge, it referred to "meetings where dentists expressed their grievances to a member of the state legislature." (*Id.* at 22.)

After the Dentists pointed out in their Third Circuit brief that Blue Shield had failed to challenge this part of the District Court's decision, Blue Shield meekly claimed, in a footnote in its reply brief, without any elaboration, that its sham claims were part of the "Dentists' broad-based conspiracy." (Reply Br., at 18n.9.) This single obscure footnote in Blue Shield's reply brief should not have operated to preserve Blue Shield's sham claims — the Dentists were placed at the severe disadvantage of not being able to provide the panel with a written response. Consistently, other circuits have refused to consider claims not raised and argued in the appellant's principal brief. *See Blesdoe v. Garcia*, 742 F.2d 1237, 1244 (10th Cir. 1984); *Pignons S.A. de Mecanique v. Polaroid Corp.*, 701 F.2d 1, 3 (1st Cir. 1983); *Chicago & West Indiana R. Co. v. Motorship Buko Maru*, 505 F.2d 579, 581 (7th Cir. 1974); *Mississippi River Corp. v. FTC*, 454 F.2d 1083, 1093 (8th Cir. 1972); *United States v. White*, 454 F.2d 435, 439 (7th Cir. 1971), *cert. denied*, 406 U.S. 962 (1972); *Platis v. United States*, 409 F.2d 1009, 1012 (10th Cir. 1969).

As for the important constitutional issues at stake, Blue Shield had no argument in either of its Third Circuit briefs. Rather, it conceded that the "Dentists' legislative petitioning and court challenges to Blue Shield's dental program touch upon arguably immune activity." (Reply Br. at 17.) It could not responsibly even make the argument that the petitioning was not genuine or was a "sham." *Compare, for example, California Motor Transport*, 404 U.S. at 511-515 ("sham" petitioning not immune). Blue Shield was silent for good reason — as noted above, the Dentists' efforts often met with success. *See Noerr*, 365 U.S. at 144 (successful efforts not actionable).[8] Moreover, Blue Shield could not argue that the Dentists' activities had perverted the petitioning process, since it had directly admitted in interrogatories that its access had not been denied. (J.A. 3710 ¶8.) *See generally California Motor Transport*, 404 U.S. at 511-15 (rationale underlying "sham" exception is to protect access to government of targeted party). In sum, Blue Shield made no attack on the District Court's dispositon because, as the District Court had correctly found, Blue Shield's claims were "not supported by any facts or law." (Pet.App. 61a.)

Nevertheless, the Third Circuit reversed *sua sponte*, and remanded the petitioning claims for trial. (Pet.App. 16a.) The Court did so in extremely cursory fashion, by establishing an unprecedented quantitative test for determining whether legislative petitioning is immune from the Sherman Act. Specifically, the Court stated:

> We are equally unimpressed with the organized dentists' efforts to characterize their challenged conduct as mere solicitation of governmental action with respect to passage and enforcement of laws. [Citing *Noerr*.] Any such activities were minor when compared to the massive efforts

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8. In this regard, for Blue Shield to have challenged the successful efforts by the Dentists to get bills through the Pennsylvania House of Representatives, Blue Shield would have had to seek the outright reversal of *Noerr*. Moreover, Blue Shield presumably would have had to argue that a majority of the members of the Pennsylvania House of Representatives were part of an antitrust conspiracy, or dupes, or the like.

> directed toward convincing the dentists collectively to resist participation contracts.

(Pet.App. 16a.)

This holding will eliminate the right of any persons to petition the government when they have engaged in other, allegedly anticompetitive actions. Such a result cannot be reconciled with *Noerr*, which established as the only relevant inquiry in such cases the issue of whether the petitioning itself is "a genuine effort to influence legislation and law enforcement practices." 365 U.S. at 144.

Alternatively, the panel's ruling could be interpreted to mean that if admittedly genuine petitioning is somehow part of a broader anticompetitive scheme, then the petitioning is not immune. In *Pennington*, however, this Court rejected just such an assertion, stating:

> Joint efforts to influence public officials do not violate the antitrust laws even though intended to eliminate competition. Such conduct is not illegal, either standing alone or as part of a broader scheme itself violative of the Sherman Act.

Pennington, 381 U.S. at 670.

If not corrected, the Court of Appeals' hasty and unsolicited reversal of summary judgment, based on unprecedented and incorrect legal standards, will subject the Dentists' legitimate petitioning activity to prolonged trial and possible injunctive restraint. Immediate review on this issue is extremely important because the Dentists even now are in the midst of a new legislative session seeking the passage of bills on a variety of topics which could affect the Dentists and Blue Shield. As it stands, the Third Circuit's holding will allow persons confronted by legitimate petitioning to thwart constitutionally-protected activities by simply filing questionable antitrust lawsuits and dragging them out through time-consuming and expensive trials.[9]

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9. With recent annual premium revenues alone of over $1.4 billion, Blue Shield is well-positioned to pursue such practices against the Dentists.

2. Certiorari Should Be Granted To Return to this Court's Holdings that There Are Limits on Drawing Inferences and Making Presumptions Under the Rule of Reason.

The Third Circuit has abandoned the traditional limits established by this Court on the permissible use of inferences and presumptions in antitrust cases. Specifically, the Third Circuit now requires that, in disposing of summary judgment motions, its district courts accept completely hypothetical presumptions of anticompetitive effects under the rule of reason. This disregard for the traditional and logical limits on a court's power to "fill in the gaps" of an antitrust plaintiff's case will render it impossible to dispose of unfounded antitrust cases prior to trial.

The Court of Appeals decision in this case completely abolishes a basic distinction between the *per se* rule and the rule of reason — the presumption of anticompetitive effects versus an evidentiary review to see whether there are effects which, on balance, "promote competition or suppress competition." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 691 (1978). *See, e.g., Times-Picayune Pub. Co. v. United States*, 345 U.S. 594, 614-22 (1953) (containing in-depth discussion of actual market effects under rule of reason); *Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918) (court should review effects, and where restraint is novel or market is not understood, should also review motives to predict effects under rule of reason). *See generally* L. Sullivan, *Handbook of the Law of Antitrust*, at 194 (1977) (inquiry into actual effects of challenged conduct is most probative "of social consequences"). The Third Circuit's conflation of the two standards resulted from a nominal application of the rule of reason and simultaneous presumption of anticompetitive effects, without any evidence whatsoever to support the presumption. (Pet.App. 9a-11a.) The Third Circuit's sole basis for proceeding in that manner was this Court's decision in *Indiana Federation of Dentists*, which the panel believed "required" the presumption of anticompetitive

effects in this case regardless of the lack of supporting evidence. (Pet.App. 11a.) This is a serious misreading of *Indiana Federation*.

This Court in *Indiana Federation* held the agreements there violated the rule of reason only after finding evidence of "actual, sustained adverse effects on competition in those areas where IFD dentists predominated. . . ." 106 S.Ct. at 2019.[10] Thus, it is still necessary under the rule of reason to determine the effects on competition, if any, of alleged restraints.[11]

The District Court, whose rule of reason analysis was disapproved by the Third Circuit, did just this and found "no evidence of aberrations of supply or demand and no evidence that dentists do not, on an individual dentist-by-dentist basis, set and charge fees on the basis of such appropriate factors as the individual dentist's skills. . . ." (Pet.App. 47a ¶1.) The District Court also found "no evidence presented that the purpose or effect of the dentists' . . . [activities] was to fix dental fees or to stabilize them." (*Id.*¶2)

A review of the summary judgment record shows that the District Court was correct. Blue Shield's theory of anticompetitive effect resulting from the participation resolutions in 1974 and 1975 is "[a]n increase in the net cost to Blue Shield dental subscribers. . . ." (Blue Shield Reply Br. filed 10/20/86, at 2n.1.) This theory is completely unsupported by the record.

To begin with, Blue Shield payments to dentists in the majority of instances have equalled the dentists full charges, and there is no balance billing that would raise the costs to subscribers. (J.A. 3497 §42.)[12] In the remaining few instances, there may

10. The "actual, adverse effects" in *Indiana Federation* were that, in counties where the Federation was powerful, "insurers . . . were . . . actually unable to obtain compliance with their requests for submission of x-rays." *Id.*

11. In *Matsushita*, 106 S.Ct. at 1359, this Court concluded that the lack of effects over two decades was "strong evidence" of no illegal conspiracy.

12. The Third Circuit disregarded *Matsushita* and apparently did not read the record as a whole to consider whether the asserted anticompetitive effect plausibly could have occurred. If it had done so, it would have come across a very material fact regarding the so-called "discounts": The Blue Shield payments to individual dentists, in the majority of instances, have equalled the dentists' full charges. (J.A. 3497 ¶42.) In other words, for all practical purposes,

be a difference between what dentists charge and what Blue Shield pays. Even then, the real issue is whether patients have had to pay the difference in these cases, because the level of dentist participation had dropped. Revealingly, Blue Shield has not produced one single patient who says that, in the isolated instances where Blue Shield pays less than the dentist's full fee, the patient has been unable to find a participating dentist to obtain the discount. Given the alleged age and statewide extent of the "conspiracy," and the extensive discovery conducted, this total failure of evidence on a key point should have been fatal to Blue Shield's case under the rule of reason.

In sum, the Third Circuit's "rule of reason" analysis, purportedly based upon *Indiana Federation*, failed to examine the very issue of anticompetitive effects which actually was dispositive in *Indiana Federation*. The result is that, without any competitive consequence of record, advisory resolutions of professional dental associations have been held *per se* violative of the Sherman Act. This result conflicts with the line of precedents established by this Court, beginning with *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), and ending with *Indiana Federation*, holding that professional considerations dictate rule of reason analysis of actual competitive effects. Immediate review is appropriate to correct the Third Circuit's maverick deviation from this recognized standard.

NOTES *(Continued)*

there is no discount in most cases.

This not only is persuasive evidence that the theorized anticompetitive effect has not occurred as a result of the 1974 and 1975 resolutions, but also is indicative of the fact that the Dentists had no real economic motive to engage in a statewide conspiracy for twelve years. *See Matsushita*, 106 S.Ct. at 1359-60. In fact, the evidence shows that the Dentists were concerned about quality of care when passing the resolutions. (*See, e.g.*, J.A. at 512.1-542.8; 750-750.1; 1434-37; 2629-33; 4361; 4482-83; 4591; 4603; 4657¶5; and 8428.)

3. Certiorari Should Be Granted To Protect Due Process and To Promote the Consistent and Orderly Administration of Justice.

On a number of issues, the Third Circuit reversed in a fundamentally unfair manner, sometimes *sua sponte* and often without any proper evidence before it to support its actions. This conduct deprived the Dentists of due process of law.

Under the law as enunciated by this Court and followed in the other circuits, in order to reverse the District Court, the Third Circuit was required to find that Blue Shield could set forth a theory of injury which was supported by admissible evidence.[13] In making its critical injury findings, the Court of Appeals:

> *Point A:* unfairly allowed Blue Shield to advance a theory of injury which, even if proven, would contradict the law of the case;
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> *Point B:* irrationally relied on affidavits to establish a triable issue even though the affiants cannot testify at trial;
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> *Point C:* relied on "sham" affidavits from these witnesses who cannot testify;
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> *Point D:* relied on a damages affidavit from an expert which made critical assumptions unsupported by any evidence, even though the Third Circuit previously had dismissed the Dentists' claims in the same case by finding the *same assumptions* by the Dentists' expert were unsupported.

In addition to its actions regarding injury, the Third Circuit:

> *Point E:* reversed on claims which were not even argued by Blue Shield;

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13. *See Matsushita*, 106 S.Ct. at 1355-56; *Keogh v. Chicago & Northwestern Railway Co.*, 260 U.S. 156, 164-65 (1922); *Van Dyk Research Corp. v. Xerox Corp.*, 631 F.2d 251, 254-46 (3d. Cir. 1980), *cert. denied*, 452 U.S. 905 (1981); *Merit Motors, Inc. v. Chrysler Corp.*, 569 F.2d 666, 670 (D.C.Cir. 1977). *See generally* 15 U.S.C. §§15 & 26 (permitting private causes of action only to persons injured or threatened with injury.)

Point F: reversed as to all Dentists, even though there was no evidence to support any claims whatsoever against many of them; and

Point G: disregarded important constitutional defenses that were raised.

Taken either separately or as a whole, these actions have denied the Dentists their due process right to the fundamental fairness of a "regularized, orderly process of dispute settlement" through the courts. *Boddie v. Connecticut*, 401 U.S. 371, 375 (1971). *See generally Schall v. Martin*, 467 U.S. 253, 263 (1984); *Lassiter v. Department of Social Services of Durham County, N.C.*, 452 U.S. 18, 24 (1981); *Powell v. Alabama*, 287 U.S. 45, 67 (1932); *Hebert v. Louisiana*, 272 U.S. 312, 316 (1926). These inconsistent, arbitrary, and improper actions have also made it impossible for the District Court to proceed logically on remand. For both of these reasons, immediate review is necessary.

Point A. Blue Shield's theory of injury is: Because "many purchasers of dental programs desire service benefit coverage [which protects their employees] against balance billing," the alleged reduction "in the level of Blue Shield par dentists resulting from the Dentists' collective activities" caused Blue Shield to lose dental sales. (Blue Shield Br. filed 9/2/86, at p. 21.) The Third Circuit adopted the unsupported theory that a reduced percentage of participating dentists adversely affected Blue Shield's sales (Pet.App. 12a) — despite Blue Shield's uncontradicted admission in discovery that it had lost no sales (J.A. 3594), and despite Blue Shield's increasingly dominant share of the prepaid dental sales market in Pennsylvania, where it is by far the largest seller with a 32-35% share. (J.A. 3618-27; 3636-38).

Importantly, that theory directly contradicts the conclusion Blue Shield successfully urged the Third Circuit to accept earlier. In the context of its motion for summary judgment against the Dentists' claims, Blue Shield asserted that the existence of participating dentists was "of no appreciable difference to the consumer." (J.A. 3590.) Blue Shield then asserted

that it competed directly with commercial carriers which do not have participating dentists. The Court of Appeals at that point agreed with Blue Shield:

> The parties disagree over the definition of [the relevant market]. [The Dentists] define [the relevant market] as the statewide market for the purchase of dental services in bulk pursuant to participating dentist agreements in which Blue Shield and Delta Dental are the only purchasers. They argue that in this market Blue Shield has a 91% market share. Blue Shield would define the statewide market more broadly. It contends that this market should include all purchasers of dental services in bulk, and not only Blue Shield and Delta Dental. *Affidavits of chief executive officers of Blue Shield's competitors for dental insurance business and affidavits of twelve persons who arrange for the purchase of dental insurance plans for Pennsylvania businesses and companies support Blue Shield's contention that from the perspective of purchasers of dental care coverage, Blue Shield, Delta Dental, other health service corporations, and commercial carriers are all in direct competition with each other. . . .*
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> . . . .
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> . . . We agree with the District Court and conclude that [the Dentists'] monopoly argument, which hinged on their definition of [the relevant market], must fail.

(Pet.App. 89a, 92a.) (Emphasis added.)

The "affidavits" which the Court of Appeals referred to in the above-cited excerpt previously stood for the proposition, in Blue Shield's words, that participating dentists did not matter to purchasers of dental programs. (J.A. 3590.)

Blue Shield then submitted new testimony from some of these same affiants opposing the Dentists' Motion for Summary Judgment. These people now claim they did not buy Blue Shield dental insurance because of an allegedly low percentage of participating dentists in their area. These new, contradictory

affidavits are the very basis of the Third Circuit's current conclusion of lost sales:

> Affidavits on file contain evidence from which a fact finder could conclude that, in selling group dental insurance, the level of participation — i.e., the extent to which insured parties would be protected from balance billing — is a significant factor in choosing among competing plans. These affidavits document specific instances in which the low level of participation by dentists in the geographic region covered by the purchasing group was a material factor in Blue Shield's loss of the group business. . . .

(Pet.App. 12a.)

The Third Circuit's consideration of Blue Shield's new injury theory and supporting, contradictory affidavits constitutes an extremely prejudicial failure to follow the law of the case doctrine. The law of the case should have applied here so that "none of the questions which were before the court on the first [appeal] . . . [were] reheard or examined on the second." *United States v. Camou*, 184 U.S. 572, 574 (1902). Here, the Third Circuit not only improperly re-examined the issue of whether the existence of participating dentists mattered to purchasers of prepaid dental programs, but it contradicted the Court's previous holding on the issue and allowed Blue Shield to win both times.[14]

This is the worst result which could possibly obtain. Not only are there now inconsistent decisions of the Third Circuit on the same question in the same case, but the decisions both have

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14. This is even more improper than the case where the party who has lost the issue previously attempts to raise it again, *see Hayman Cash Register v. Sarokin*, 669 F.2d 162 (3d Cir. 1982); *Todd and Co., Inc. v. SEC*, 637 F.2d 154 (3d Cir. 1980). Here, Blue Shield previously won the issue in defense of the Dentists' claims, and now has won again by contradicting the first decision.

gone against the Dentists. This is fundamentally unfair. Immediate review is necessary to establish consistency.[15]

Point B. The Third Circuit's reliance on the affidavits submitted by Blue Shield to show lost sales injury makes no sense under Rule 56, and undermines the case management and control orders promulgated by the District Court for this complex antitrust case. None of these affiants — including the expert witness — were listed as witnesses in Blue Shield's preclusive pretrial memorandum to support its Counterclaim.[16] Blue Shield filed no motion to supplement its pretrial memorandum to permit the non-expert affiants to testify at trial. It made no sense, therefore, for the Court to have considered those affidavits as establising a triable issue of fact on the injury question under Rule 56.

The Third Circuit's consideration of the testimony of witnesses not scheduled to testify eviscerates the District Court's ability to manage the course of complex cases. The *Manual for Complex Litigation* (1977 ed.) suggests, for example, that good case management dictates "parties should be precluded from offering in evidence" any factual matters "not included in final pretrial briefs." *Manual*, §3.30. Case law, including the Third Circuit's, has consistently followed this suggestion and refused to allow summary judgment to be defeated by considering evidence not listed. *See, e.g., Southern Cal. Retail Clerks Union & Food Employers Joint Pension Trust Fund v. Bjorklund*, 728 F.2d 1262, (9th Cir. 1984); *In re Japanese Electronic Products*, 733 F.2d 238, 255 (3d Cir. 1983), *rev'd on other grounds sub*

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15. As it currently stands, the District Court on remand will now be faced with inconsistent holdings of the Court of Appeals on a key issue — what is the significance of participating dentists to purchasers of dental plans. Therefore, either the current judgment should be reversed, or, if the case is to be remanded on the basis of Blue Shield's current theory of injury, the previous judgment against the Dentists should be opened to allow the Dentists to proceed on their claims as well.

16. The affidavits were from Raymond Barth of the Holy Spirit Hospital, in Harrisburg; W. Russell Faber of the Senate of Pennsylvania; and Paul J. Feldstein, Blue Shield's new economic expert. (Pet.App. 12a, note 3.)

nom., Matsushita Electric Industrial Co. v. Zenith Radio Corp., 106 S.Ct. 1348 (1986).

In its zeal to protect the desires of the antitrust plaintiff in this case to have a needless, time-consuming and expensive trial, the Third Circuit lightly brushed aside the fact that the affiants allegedly establishing triable issues will not testify at trail: "The organized dentists do not contend . . . that the pretrial order provided for preclusive effect with respect to materials which could be submitted in opposition to a motion for summary judgment." (Pet.App. 13a.) This statement is absolutely inaccurate.[17] Not less than four separate times in their Brief to the Third Circuit (Dent.Br. at 19, 22, 26, 27), and at oral argument, the Dentists specifically articulated the position that summary judgment could not be defeated based on the affidavits in question because the affiants were not listed.

The Third Circuit's irrational reliance on witnesses who will not testify, its cavilier attitude toward the District Court's case management, and its total disregard for orders of the District Court should be corrected immediately. Certiorari should be granted to give meaning to Rule 56 and to vindicate the authority of federal trial courts to manage and issue preclusive pretrial orders in complex antitrust cases.

Point C. As noted previously (Point 3A, *(supra)*, the two affidavits from non-experts on which the Third Circuit relied to establish fact of injury were from witnesses who submitted other, contradictory affidavits. One witness — Raymond J. Barth — had submitted an affidavit in defense of the Dentists' claims against Blue Shield which stated, in pertinent part:

> I decided to place Holy Spirit Hospital's group dental insurance with Connecticut General because the price quoted by Connecticut General was slightly lower than the price quoted by Pennsylvania Blue Shield. In addition,

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17. Even if the Dentists had failed to make the contention, the materials should not have been considered anyway out of respect for the District Court's scheduling order (J.A. 2439) (precluding use in *any* "future proceedings").

> Connecticut General offered what I perceived to be a slightly superior program with respect to administrative services.
>
> . . . .
>
> The availability under the Blue Shield program of 'participating doctors' is not a significant benefit in my opinion. . . .[T]he 'participating ' aspect of the Blue Shield plan can create employee relations problems when some employees, who do not use the services of participating doctors come to believe that other employees who do use such doctors, are receiving better benefits. . . For these reasons, *I gave no weight to the 'participation' feature of the Blue Shield dental program in making my decision in respect to the hospital's dental coverage.*

(J.A. 2738-41, ¶'s 6 & 8) (emphasis added.)[18]

The affidavit of W. Russell Faber was relied upon by the Third Circuit to show that the Pennsylvania Senate did not purchase from Blue Shield "because of low dentist participation." (Pet.App. 12a, note 3.) However, the Faber affidavit cited by the Court contradicts another Faber affidavit which shows that Faber wrote a letter to Blue Shield in 1982 and stated the reason it did not get the Senate's business was because Blue Shield did not pay out enough in dental benefits. (J.A. 6838 ¶'s 11-12, and 6840-41.)

After years of discovery, these two unlisted affiants are Blue Shield's sole factual basis for showing lost sales. The Third Circuit's reliance on such evidence to reverse summary judgment, and to allow claims of an alleged twelve year-old statewide conspiracy to proceed to trial, exceeded all bounds of reason. Indeed, the Court's reliance on such evidence conflicts with the other circuits, which hold that contradictory affidavits are

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18. The new Barth affidavit, upon which the Third Circuit relied in remanding this case for trial, inconsistently states that "the lack of a sufficient number of Blue Shield participating dentists constituted 85% of my reason for selecting Connecticut General instead of Pennsylvania Blue Shield. . . ." (J.A. 8958 ¶8.)

"shams" which do not present "genuine issues" for trial as required by Fed.R.Civ.P. 56(c). *See e.g., Miller v. A. H. Robins Co., Inc.*, 766 F.2d 1102, 1104 (7th Cir. 1985); *Camfield Tires, Inc. v. Michelin Tire Corp.*, 719 F.2d 1361, 1365 (8th Cir. 1983); *Radobenko v. Automated Equipment Corp.*, 520 F.2d 540, 544 (9th Cir. 1975); *Perma Research & Development Corp. v. The Singer Co.*, 410 F.2d 572, 577-78 (2d Cir. 1969).

This Court should grant immediate review and confirm that a party cannot prevent summary judgment under Rule 56, and require a trial, by producing sham affidavits which present no "genuine" issue for trial. Such a statement would give this Court's further imprimatur to the increasingly effective use of summary judgment as a means of preventing costly and unnecessary antitrust trials, and would prevent parties from thwarting the fair, prompt and orderly administration of justice merely by procuring conflicting affidavits from the same witnesses.

Point D. The Third Circuit's reliance on the affidavit of Blue Shield's unlisted expert — Paul J. Feldstein — is also misplaced because Feldstein's calculations of lost sales income are based upon false or unsupported factual assumptions. The law from other circuits has long been that expert opinions based on false or unsupported factual assumptions are to be excluded from evidence, *see e.g., Shatkin v. McDonnell Douglas Corp.*, 727 F.2d 202, 208 (2d Cir. 1984); *Soden v. Freightliner Corp.*, 714 F.2d 498, 505 (5th Cir. 1983); *MCI Communications Corp. v. AT & T*, 708 F.2d 1081, 1164-66 (7th Cir.), *cert. denied*, 464 U.S. 891 (1983); *Drayton v. Jiffee Chemical Corp.*, 591 F.2d 352, 364 (6th Cir, 1978); *Scheel v. Conboy*, 551 F.2d 41, 43-4 (4th Cir, 1977), and the Third Circuit's reliance on such an expert opinion contravenes decisions which have applied this exclusionary rule to summary judgment proceedings, *see United States v. Various Slot Machines*, 658 F.2d 697, 700-01 (9th Cir. 1981); *Merit Motors v. Chrysler Corp.*, 569 F.2d at 672-73.

The Feldstein affidavit (J.A. 9025-39) is devoted almost exclusively to calculating amount of damages, rather than proving fact of injury. The affidavit simply assumes the very issue which was before the panel — that a reduced participation rate

caused reduced sales to Blue Shield. The basis for this assumption is clearly stated by Feldstein:

> I obtained data from PBS on the number of Penn Dental I contracts sold for the years 1978 through 1984. I then analyzed such data by county for each such year (1978 through 1984). During the course of my analysis, I observed that PBS' Penn Dental I sales were on the average higher in areas where PBS had a relatively higher level of dentist participation than in areas where a relatively lower level of dentist participation prevailed.

(J.A. 9032 ¶7.)

From the above excerpt, it appears that Feldstein noticed some kind of correlation between sales of Blue Shield dental programs and levels of dentist participation in different areas of Pennsylvania. Feldstein's assumption from this correlation is that reduced participation rates have adversely affected sales. Importantly, the facts of record do not support this assumption.

Indeed, the record actually contradicts Feldstein's unsupported assumption. First, there is Blue Shield's previous assertion (which became the law of the case) that the existence of participating dentists does not matter to purchasers of dental programs at all. (J.A. 3590.) (*See* Point 3A, *supra*.) Beyond this, there is the statement of Blue Shield's Vice-President of Sales which supports a directly contrary assumption — to the extent that there is a correlation between Blue Shield sales and the level of dentist participation, *sales* affect *participation*, and *not* the converse.[19] Finally, there is the direct admission of Blue Shield's Vice-President of Marketing Services that no sale was ever lost as a result of too few participating dentists. (J.A. 3593-94.)

The Third Circuit's complete acceptance of Feldstein's conclusion that a reduced level of participation has adversely affected Blue Shield sales was based solely on the asserted

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19. Specifically, the Blue Shield official stated that one of the reasons for Blue Shield's "less-than-optimum showing [of the number of participating dentists in York County is that Blue Shield's] market penetration is not as high [there] . . . as it is in other counties." (J.A. 3645.)

correlation testified to by Feldstein. (Pet.App. 13a.)[20] Without one genuine instance properly in the record showing that insufficient participation lost any particular sale, with admissions to the converse by Blue Shield's marketing department. (J.A. 3593-94 & 3645), and with the law of the case holding that dentist participation is of no consequence to purchasers, such an unsupported and improper embrace of Feldstein's conclusions by the Third Circuit cannot be allowed to stand. *See MCI Communications Corp. v. AT & T*, 708 F.2d at 1164-66; *Various Slot Machines*, 658 F.2d at 700-01; *Merit Motors*, 569 F.2d at 672-73.

Immediate review would be necessary solely to correct the Third Circuit's far too lenient standard for accepting expert testimony as a basis for permitting expensive, unmeritorius antitrust cases to go to trial. Here, however, there is even more reason for immediate review. The Court's error in this case rises to the level of a denial of due process when it is compared with the Third Circuit's previous decision dismissing the Dentists' Sherman Act claims against Blue Shield. There, the Court employed a more stringent, albeit correct, standard:

> [F]or their part, [the Dentists] relied solely on an affidavit by Dr. Comanor, an economist . . . — an affidavit that expressed an opinion based on factual assumptions for which [the Dentists] cited no support in the record . . . (Footnote omitted.)
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> . . . .
>
> In *Merit Motors, Inc. v. Chrysler Corp.*, 569 F.2d 666 (D.C.Cir. 1977), the court, speaking through Judge J. Skelly Wright, emphasized that the factual predicate of an expert's opinion must find some support in the record. We agree with that court's decision and its reasoning. . . .

(Pet.App. 89a & 91a.)[21]

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20. No market study has every been produced. The Court and the Dentists had to rely solely on the assertions in Feldstein's affidavit.

21. Significantly, the fact which found no support in the record was that participating dentists were of some significance to purchasers of dental

The employment of inconsistent standards regarding the admissibility of expert opinions of opposing parties in the same case, *based upon the same unsupported assumptions*, is a denial of due process.

Point E. The Third Circuit's *sua sponte* reversal of summary judgment as to the Dentists' direct petitioning denied the Dentists a fair opportunity to present a defense on the merits. Because Blue Shield never listed or argued its "sham" claims in its principal brief on appeal,[22] the Dentists were placed at the severe disadvantage of not being able to provide the panel with a written response. The *sua sponte* reversal by the panel, in and of itself, therefore is a denial of due process. *See American Surety Co. v. Baldwin*, 287 U.S. 156, 168 (1932) (due process requires an opportunity to present a full defense to all claims).

As noted previously (Point 1, *supra*), other circuits have recognized the prejudice resulting from consideration of claims not raised and argued in the appellant's principal brief. Exacerbating the unfairness of the Third Circuit's *sua sponte* reversal in this case is the fact that the Court earlier had dismissed the Dentists' rule of reason claims against Blue Shield on the ground that their "discussion was so cursory" in their brief that the Court deemed the claims "abandoned." (Pet.App. 79a, note 4.) This time around, Blue Shield did not set forth even a "cursory" discussion in its argument, yet the Court reversed.

The Third Circuit's consideration and reversal, without an opportunity for the Dentists to present a defense, deprived the Dentists of the process of law fundamental to the concept of a scheme of ordered liberty.

Point F. The Third Circuit remanded the entire case, against all fifteen Defendants, without even mentioning six of the Defendants — Odontological Society of Western Pennsylvania, Delaware Valley Dental Society, Dennis W. King, D.D.S., Theodore R. Paladino, D.D.S., Thomas L. Perkins,

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programs. (*See* Point 3A, *supra*.) Now, Blue Shield's new, unlisted economic witness has assumed that same fact without proper record support, and the Third Circuit has accepted the assumption.

22. As noted earlier (Point 1, *supra*), Blue Shield did not do any better in its reply brief.

D.M.D., and Kay F. Thompson, D.D.S.[23] The reason for this failure is simple — the undisputed record is particularly clear that these Defendants did nothing violative of the Sherman Act. Thus, the Third Circuit's reversal of summary judgment as to these Defendants was manifestly unfair and contrary to fundamental concepts of ordered liberty.

This Court has held that a judgment supported by no evidence on an essential element violates due process. *See Vachon v. New Hampshire*, 414 U.S. 478 (1974); *Thompson v. Louisville*, 362 U.S. 199 (1960). The Court should now also recognize that a failure to award summary judgment despite the lack of evidence, especially in expensive and protracted antitrust litigation such as this, also violates due process.

Point G. The Court of Appeals grossly abused its discretion by completely ignoring important constitutional defenses which mandated affirmance of summary judgment. In particular, the Court reversed summary judgment on Blue Shield's claims that there has been a concerted resistance to in-office reviews of dental records, by stating:

> There is . . . ample evidence that the Pennsylvania Dental Association advised dentists by letter that they should resist disclosure to Blue Shield of certain patient information sought by it in the course of in-house reviews.

(Pet.App. 7a.)

The two form letters to which the panel referred are in the record. (J.A. 8568-70; 9139-41.) Even a cursory reading of the letters reveals clearly that they do not advise dentists to resist disclosure of anything. Rather, all the letters do is give dentists confronted by a Blue Shield audit certain protected legal advice regarding their rights and responsibilities.

In their brief to the Third Circuit, the Dentists noted that they have engaged only in the protected associational activity of giving legal advice. (Dent.Br. at 45.) In *NAACP v. Button*, 371

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23. For example, the panel's recitation of the "facts" it considered relevant appears at pages 5 through 8 of its opinion, Pet.App. 5a-8a. Nowhere are any facts mentioned about any of the six Defendants.

U.S. 415 (1963), this Court expressly recognized the right of an association to give and obtain legal advice. 371 U.S. at 428-29, and 434.

The Court of Appeals completely ignored this argument, and instead mischaracterized it to say that the Dentists were claiming that the *participation resolutions* of 1974 and 1975 were legal advice. The Court then addressed this "straw man":

> Relying on *NAACP v. Button*, 371 U.S. 415 (1963), the organized dentists also urge that we should affirm the summary judgment on the theory that they have a first amendment right to offer legal advice to members of the dental profession. If the departicipation resolutions were intended as legal advice, then it was extraordinarily bad. . . .

(Pet.App. 16a.)

The Court of Appeals' blatant disregard for constitutional defenses clearly articulated to it demonstrates an inability to be fair in the administration of justice.

Point H. The Third Circuit's inconsistent decisions and standards, its disregard for orders of the District Court, and its other actions outlined here, when taken as a whole, have destroyed the orderly conduct of this case. After six years of litigation, the Third Circuit has remanded the case to the District Court, presenting it with a muddled record; an inconsistent law of the case; a host of irrational and unsupported inferences and presumptions; and a rejection of the District Court's preclusionary orders.

Neither the Dentists nor the District Court, which has acted consistently and thoughtfully based upon the record as a whole, deserves this. Certiorari should be granted to prevent this result, and to uphold the rights of the Dentists to due process of law.

CONCLUSION

For the foregoing reasons, petitioners respectfully pray that the Court issue a writ of certiorari to review the judgment of the Uinted States Court of Appeals for the Third Circuit.

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 86-5338

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a Pennsylvania Blue Shield,

Appellant

v.

York County Dental Society,
Fifth District Dental Society,
Dennis W. King, D.D.S.
Charles M. Ludwig, D.D.S.
Theodore R. Paladino, D.D.S.
Thomas L. Perkins, D.M.D.
and Kay F. Thompson, D.D.S.

3rd Party Counterclaim Defts.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA - SCRANTON

(D.C. Civil No. 81-1187)

ARGUED
January 20, 1987
Before GIBBONS, *Chief Judge*,
WEIS and HUNTER, *Circuit Judges*

(Opinion Filed: MARCH 30, 1987)

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OPINION OF THE COURT

GIBBONS, *Chief Judge*:

Medical Service Association of Pennsylvania, doing business as Pennsylvania Blue Shield (Blue Shield), appeals from a summary judgment in favor of ten dental associations and five individual dentists (collectively referred to as "the organized dentists")[1] dismissing Blue Shield's claims under section 4 and section 16 of the Clayton Act, 15 U.S.C. §§ 15, 26 (1982 & Supp. III 1985), as well as pendent state law claims. Blue Shield alleges that the organized dentists engaged in concerted activity in violation of section 1 of the Sherman Act, 15 U.S.C. § 1 (1982 & Supp. III 1985), by successfully exhorting Pennsylvania dentists to refuse to contract with Blue Shield to provide dental services to Blue Shield subscribers. The district court granted the organized dentists' motion for summary judgment

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1. The appellees are the Pennsylvania Dental Association, the Delaware Valley Dental Society, the Erie County Dental Association, Inc., the Harrisburg Area Dental Society, the Luzerne County Dental Society, the Montgomery-Bucks Dental Society, the Odontological Society of Western Pennsylvania, the Scranton Dental Society, the York County Dental Society, the Fifth District Dental Society, Dennis W. King, D.D.S., Charles M. Ludwig, D.D.S., Theodore R. Paladino, D.D.S., Thomas L. Perkins, D.M.D., and Kay F. Thompson, D.D.S.

on the antitrust claims and dismissed Blue Shield's pendent state law claims without discussion.[2] We reverse.

I.

Blue Shield is a non-profit health services insurance company incorporated under the Pennsylvania Health Services Plan Corporations statute. 40 Pa. Cons. Stat. Ann. §§ 6301-6335 (Purdon 1986). It provides subscribers with prepaid medical, dental, and related health services. Blue Shield's dental coverage plan invites dentists to become participants by agreeing to accept reimbursement from Blue Shield for services rendered, but it limits such reimbursement to a percentile of the usual charges of dentists of a similar specialty. Blue Shield subscribers are permitted, under the plan, to use the services of non-participating dentists, but those dentists are free to charge patients the difference between what Blue Shield will pay and what they decide to charge. This practice is known as balance billing. The participating

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2. The summary judgment was granted on Blue Shield's third-party counterclaim. The litigation has had a complex history. It originated when the Commonwealth of Pennsylvania filed a complaint against the organized dentists, charging that they violated the antitrust laws by encouraging dentists to terminate Blue Shield participating dentist agreements. The organized dentists filed a counterclaim against the Commonwealth and a third-party complaint against Blue Shield. Blue Shield answered, and filed the third-party counterclaim with which this appeal is concerned. The Commonwealth and the organized dentists entered into a settlement which resulted in dismissal of the original complaint and counterclaim. Thereafter, Blue Shield moved for and obtained summary judgment in its favor on the organized dentists' third-party complaint, and this court affirmed. Pennsylvania Dental Assn. v. Medical Service Assn. of Pennsylvania, 574 F.Supp. 457 (M.D.Pa. 1983), *aff'd*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985). That left pending Blue Shield's federal and state law claims against the organized dentists.

dentists undertake not to engage in that practice. Thus, the economic effect of becoming a participating dentist is to agree to sell services to Blue Cross for its subscribers at what in many cases will be a discount. The benefits of becoming a participating dentist are direct payment from Blue Cross and increased patronage from Blue Cross subscribers seeking to avoid balance billing.

To assure itself that insured and non-insured dental care prices are commensurable, Blue Shield requires dentists to submit to in-office reviews. These reviews of insured and non-insured patients' files take place at both participating and non-participating dentists' offices. Comparisons are made by Blue Shield for the purpose of determining standard dental service fees. Blue Shield also requires both participating and non-participating dentists to certify on claim forms that the charges are their most frequent charges.

Blue Shield sells its prepaid dental services plan on a group-only basis. It sold its first group plan in January of 1972. That plan met with initial market success. By the middle of 1974, Blue Shield had achieved the goal of having 70% of the state's dentists as participating dentists. About that time, however, Blue Shield began to encounter resistance from the organized dentists. Eventually, a large number of dentists withdrew from participation.

II.

The summary judgment in this case does not present the problem of drawing inferences of conspiracy from circumstantial evidence. *See Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 106 S.Ct. 1348 (1986). The record contains an abundance of direct evidence of concerted action by the organized dentists intended to encourage Pennsylvania dentists to withdraw from or to avoid the

status of Blue Shield participating dentists. That evidence includes: action by the Executive Board of the Erie County Dental Association, Inc., recommending that its members drop their participating dentist relationship; a resolution by the Erie County Dental Association membership opposing the concept of participating dentists and recommending that its members withdraw; publication by the Harrisburg Area Dental Society of its Dental Insurance Manual, which advocates a uniform and unified position by dentists in opposition to Blue Shield review of patient records for the purpose of determining commensurability of charges; a resolution by Fifth District Dental Society -- which includes the Harrisburg Area Dental Society and other groups -- that its membership should avoid contractual relationship with intermediaries like Blue Shield; a resolution by the Scranton District Dental Society that its members should not become participating dentists; and a resolution by the Luzerne County Dental Society requesting that its members become non-participants in the Blue Shield program.

There is also evidence that written pledges were circulated requiring undertakings by dentists to resign from participation. Various individual defendants, particularly Charles M. Ludwig, president-elect and later president of the Pennsylvania Dental Association, conducted individual meetings with dentists in which the dentists were urged to withdraw from participation. Moreover, officials of the Pennsylvania Dental Association met with Blue Shield representatives and informed Blue Shield that unless it modified the cost containment efforts to which the organized dentists objected, more resignations would take place. At the annual meeting of the Pennsylvania Dental Association House of Delegates, the

Association's president expressed the hope that Blue Shield would yield. When Blue Shield did not yield, further departicipation resolutions were passed by other organized dental groups, including the York County Dental Society and the Montgomery-Bucks Dental Society. The Erie County Dental Association and the House of Delegates of the Pennsylvania Dental Association, organizations which had already passed departicipation resolutions, renewed them. Not surprisingly, there is ample direct evidence that all of the defendants acted in concert on the issue of departicipation to put maximum pressure on Blue Shield to yield on its cost containment program. There is also ample direct evidence that the Pennsylvania Dental Association advised dentists by letter that they should resist disclosure to Blue Shield of certain patient information sought by it in the course of in-house reviews.

Following the meetings at which departicipation resolutions were adopted, there were mass withdrawals of participation by dentists. The percentage of participating dentists statewide, as compared to all dentists who submitted claims to Blue Shield, declined from greater than 72% in 1974 to less than 54% in the early 1980s.

In 1978, following the decisions in *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977), and *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), one of the defendants, the Harrisburg Area Dental Society, was advised by counsel with respect to the legality of its Dental Insurance Manual dealing with participation in third-party dental plans. Accordingly, the Harrisburg Area Dental Society passed a resolution suspending its previously adopted policy of departicipation. That

suspension resolution was not distributed to all dentists, however, and no effort was made to nullify the effect of the previously obtained departicipation pledges. All of the remaining defendants which adopted departicipation resolutions still have such resolutions of record.

In 1977, the Pennsylvania Dental Association began to protest and challenge every filing Blue Cross made with the Pennsylvania Insurance or Health Departments affecting dental programs. It also initiated a number of court proceedings against Blue Cross. These legal maneuvers sought to establish that Blue Shield's in-house review and cost containment efforts were illegal interferences in the doctor-patient relationship. None of them proved to be successful.

Thus, unlike the more typical case under section 1 of the Sherman Act, 15 U.S.C. § 1, in which concert of action must be inferred from a trail of circumstantial evidence left by conspirators intent on concealment, this case presents a summary judgment record abounding in direct, frequent, public, on-the-record evidence of improper concerted action. It is abundantly clear that the defendants' actions were aimed both at causing participating dentists to withdraw, and at preventing Blue Shield from obtaining the information it needs to determine whether the dentists' charges to it are commensurable with their charges to uninsured patients. The district court's grant of summary judgment could be proper, therefore, only if the activities referred to: 1) were legal under the Sherman Act; 2) caused no actual or threatened antitrust injury to Blue Shield's business or property; 3) were immune; or 4) are no longer actionable because of the applicable four-year statute of limitations. 15 U.S.C. § 15b (1982). The organized dentists advance each of these contentions.

III.

The district court concluded that the concerted action outlined above was legal under the Sherman Act. Rejecting Blue Shield's argument that the organized dentists' activities evidence a group boycott aimed at coercing it into abandoning its costs containment efforts, the district court opined:

> The dentists did not have a dispute with Blue Shield, and Blue Shield was not the dentists' target. The dentists had a dispute with the notion of third-party control over dentists' otherwise independent decision-making and the target of their dispute was the participating dentist system. That Blue Shield had a stake in the dispute does not make it a target of a boycott.

This reasoning is both inconsistent with the summary judgment record and completely illogical. There is abundant evidence that the primary purpose of the departicipation movement was to coerce Blue Shield to yield on the issue of an upper limit on charges by participating dentists. The participating dentists were targets, but only in the sense that they were urged to become members of a boycott of Blue Shield's participant contract. Indeed, the participating dentists were the beneficiaries rather than the victims of the concerted action. Clearly, the target, in the sense of potential adverse economic effects, was Blue Shield.

The district court also concluded that, even assuming the activity complained of was construed to be a group boycott, it was nevertheless legal. This activity was not, the court reasoned, a *per se* violation of section 1; rather, under a rule of reason analysis, it was valid as a matter of law. In so ruling, the district court relied principally upon *Indiana Federation of Dentists v. Federal Trade Commission*, 745 F.2d 1124

(7th Cir. 1984), which was subsequently reversed in *Federal Trade Commission v. Indiana Federation of Dentists*, 106 S.Ct. 2009 (1986). In *Indiana Federation* a dental association adopted a rule requiring its members to withhold x-rays from dental insurers in connection with evaluating patients' claims for benefits. The Federal Trade Commission, employing a rule of reason analysis, held that this concerted activity violated section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45 (1982 & Supp. III 1985), and section 1 of the Sherman Act, 15 U.S.C. § 1, because it eliminated competition among individual dentists in dealing with third-party payers. The Court of Appeals for the Seventh Circuit vacated the Commission's cease and desist order on the ground that there was no evidence that the conduct of the dental association and its members had any effect on competition in the relevant market. The Supreme Court unanimously reversed. The Court rejected the dental federation's argument that the no x-ray policy had the non-economic purpose of assuring that patients receive the highest quality dental care possible. Justice White wrote:

> Application of the Rule of Reason to these facts is not a matter of any great difficulty. The Federation's policy takes the form of a horizontal agreement among the participating dentists to withhold from their customers a particular service that they desire -- the forwarding of x-rays to insurance companies along with claim forms. "While this is not price fixing as such, no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." *Society of Professional Engineers, supra*, 435 U.S. at 692, 98 S.Ct., at 1365. A refusal to compete with respect to the package of services offered to

> customers, no less than a refusal to compete with respect to the price term of an agreement, impairs the ability of the market to advance social welfare by ensuring the provision of desired goods and services to consumers at a price approximating the marginal cost of providing them. Absent some countervailing pro-competitive virtue -- such as, for example, the creation of efficiencies in the operation of a market or the provision of goods and services, *see Broadcast Music, Inc. v. CBS, supra*; *Chicago Board of Trade, supra*; cf. *NCAA v. Board of Regents of Univ. of Okla.*, 468 U.S. 85, 104 S.Ct. 2948, 82 L.Ed.2d 70 (1984) -- such an agreement limiting consumer choice by impeding the "ordinary give and take of the market place," *Society of Professional Engineers, supra*, 435 U.S. at 692, 98 S.Ct., at 1365, cannot be sustained under the Rule of Reason. No credible argument has been advanced for the proposition that making it more costly for the insurers and patients who are the dentists' customers to obtain information needed for evaluating the dentists' diagnoses has any such procompetitive effect.

Indiana Federation, 106 S.Ct. at 2018.

The Supreme Court's unanimous decision in *Indiana Federation* requires that we reject the district court's rule of reason analysis. Clearly there is sufficient evidence in the summary judgment record to support a finding that under the rule of reason there was a violation of section 1 of the Sherman Act, 15 U.S.C. § 1. Indeed, this is an *a fortiori* case. That being so, there is no reason to address the question of whether the court also erred in rejecting Blue Shield's argument that the evidence of group boycott activity should be regarded as a *per se* violation of section 1.

IV.

The organized dentists urge that even if the evidence of record establishes a *prima facie* case of a Sherman Act violation, it is not one about which Blue Shield may complain. They point out that the Federal Trade Commission's standing to redress such violations is broader than that of private litigants -- such as Blue Shield -- which must satisfy the antitrust injury require ments of section 4 and section 16 of the Clayton Act. 15 U.S.C. §§ 15, 26; *see also Cargill, Inc. v. Monfort of Colorado, Inc.*, 107 S.Ct. 484 (1986); *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977).

The organized dentists do not seriously dispute that the concerted activities complained of resulted in wholesale withdrawals by participating dentists. Rather, they contend that these withdrawals did not injure Blue Shield in its business or property, and that, even if they did, the injury was not an antitrust injury for which sections 4 and 16 of the Clayton Act afford redress.

Affidavits on file contain evidence from which a factfinder could conclude that, in selling group dental insurance, the level of participation -- i.e., the extent to which insured parties would be protected from balance billing -- is a significant factor in choosing among competing plans. These affidavits document specific instances in which the low level of participation by dentists in the geographic region covered by the purchasing group was a material factor in Blue Shield's loss of the group business.[3] There is also on file the affidavit of Paul J. Feldstein, an economist,

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3. Specifically, the affidavits reveal that Holy Spirit Hospital and the Pennsylvania Senate, both purchasers of group dental coverage from Blue Shield, terminated their Blue Shield dental plans because of low dentist participation in their geographic areas.

explaining the cross elasticity of demand among various payment provision plans for dental services. That affidavit outlines the effect of departicipation on the price of dental services. By refusing to agree to refrain from balance billing, the departicipants reduce Blue Shield's ability to compete in the prepayment market because they deny Blue Shield access to dentists who are willing to compete for business on the basis of price. Based on information of record with respect to sales, former and present levels of participation, the activities of other sellers of dental payment plans, and other relevant materials, Mr. Feldstein has made an estimate of the sales lost by Blue Shield as a result of the organized dentists' boycott, and of the resulting loss in net income. In his opinion, the activities of the organized dentists resulted in a participation rate 12.92 percentage points lower on average in each county of Pennsylvania than it would have been absent those activities. With regard to the organized dentists' resistance to in-office review, Mr. Feldstein expresses the opinion that Blue Shield's estimate of resultant damages in excess of $220,000 is a statistically valid and conservative measure of its losses from preventable overcharges.

The organized dentists levy a shotgun blast of arguments against Blue Shield's evidence of injury. Most of the pellets are not even close to the target. The pellet which perhaps comes closest to the mark is the objection that since Blue Shield's expert, Mr. Feldstein, was not listed in Blue Shield's pretrial order, his affidavit may not be considered. The organized dentists do not contend, however, that the pretrial order provided for preclusive effect with respect to materials which could be submitted in opposition to a motion for summary judgment. *See In re Japanese Electronic Products*, 723 F.2d 238, 255 (3d Cir. 1983), *rev'd on other grounds sub nom. Matsushita Electric*

Industrial Co. v. Zenith Radio Corp., 106 S.Ct. 1348 (1986). Moreover, even absent the Feldstein affidavit, other affidavits contain evidence from which lost sales of group insurance business could be found.

In the alternative, the organized dentists contend that, even assuming lost sales and lost income, Blue Shield is not a proper antitrust plaintiff. This argument has two aspects. First, the dentists urge that, because Blue Shield lost sales, other sellers of dental prepayment plans must have gained sales; hence, the conspiracy was pro-competitive. Second, they urge that Blue Shield's injury was indirect and that only Blue Shield's subscribers should be recognized as having antitrust standing.

Neither of the organized dentists' arguments addresses the injury resulting from overcharges as a result of resistance to the in-house review program. Such overcharges did not help competitors of Blue Shield to sell group dental plans. The overcharges resulted from payments Blue Shield made on behalf of Blue Shield subscribers. This injury -- i.e., the payment of overcharges as a result of a horizontal agreement to resist in-house reviews which were aimed at cost containment -- is unquestionably an antitrust injury suffered by Blue Shield *alone*. No one else can possibly complain about it. It involves no chance of duplicate recovery, and requires no apportionment of damages. The causal connection between the horizontal agreement complained of and the overcharges is patent. Thus, the summary judgment cannot be affirmed on the theory that Blue Shield suffered no antitrust injury.

Futhermore, aside from the injury to Blue Shield resulting from overcharges, a factfinder could also conclude that Blue Shield suffered antitrust injury in the form of lost sales as a result of the organized dentists' resistance to participation. Antitrust injury

is not limited to competitors of conspirators. *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 482 (1982); *Bravman v. Bassett Furniture Industries, Inc.*, 552 F.2d 90, 98-99 (3d Cir.), *cert. denied* , 434 U.S. 823 (1977). Blue Shield's interests would have been directly served by the price competition among dentists that existed prior to the horizontal arrangements taken by the organized dentists to resist successful marketing of participation contracts. It is certainly plausible that the absence of such price competition severely limited Blue Shield's ability to compete with other carriers in the market for sale of group dental insurance plans.

It is true that the dentists' horizontal agreement to resist participation also resulted in injury to Blue Shield subscribers, since its effect was that more subscribers were subject to the practice of balance billing. That damage, however, does not duplicate the lost income suffered by Blue Shield, because Blue Shield subscribers could never recover the latter. Thus, issues of duplicate recovery or apportionment of damages are not presented by the record now before us. Moreover, individual subscriber overcharges resulting from balance billing are relatively insignificant; hence, subscribers have only the slightest incentive to launch costly antitrust litigation in the public interest. Blue Shield, in contrast, as the immediate target of the organized dentists' conspiracy, is obviously the preferred private attorney general. Blue Shield is the victim "whose self-interest would normally motivate [it] to vindicate the public interest in antitrust enforcement[.]" *Associated General Contractors v. Carpenters*, 459 U.S. 519, 542 (1982). In addition, the recognition that Blue Shield is a proper antitrust plaintiff keeps "the scope of complex antitrust trials within judicially manageable limits." *Id.* at 543.

We hold, therefore, that on this record a summary judgment cannot be affirmed on the theory that Blue Shield cannot properly bring an action under section 4 or section 16 of the Clayton Act, 15 U.S.C. §§ 15, 26.

V.

The organized dentists' immunity contention is predicated primarily on the first amendment. They contend that they have associational interests in advancing the standards of professional care which motivated their actions in this case. Those interests are not so great, however, as to afford a shield to professional conduct which forecloses competition. *See National Society of Professional Engineers v. United States*, 435 U.S. 679, 697-99 (1978).

We are equally unimpressed with the organized dentists' effort to characterize their challenged activities as mere solicitation of governmental action with respect to passage and enforcement of laws. *Eastern R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961). Any such activites were minor when compared to the massive effort directed toward convincing dentists collectively to resist participation contracts.

Relying on *NAACP v. Button*, 371 U.S. 415 (1963), the organized dentists also urge that we should affirm the summary judgment on the theory that they have a first amendment right to offer legal advice to members of the dental profession. If the departicipation resolutions were intended as legal advice, then it was extraordinarily bad, since the resolutions amounted to advice to join what appears, *prima facie*, to be a conspiracy in violation of the law. Unlike the antisolicitation statute involved in *NAACP v. Button*, 371 U.S. at 419, the Sherman Act is not directed against solicitation for lawful purposes.

The activity disclosed in this record cannot as a matter of law be held to be immune from antitrust scrutiny by virtue of any associational rights protected by the first amendment.

VI.

The final alternative ground for affirmance suggested by the organized dentists is the four-year time bar in 15 U.S.C. § 15b. The third-party complaint was filed in March of 1982. It seeks both damages under section 4 of the Clayton Act, 15 U.S.C. § 15, and injunctive relief under section 16, 15 U.S.C. § 26. Although the four-year limitation period in 15 U.S.C. § 15b is applicable by its terms only to the section 4 damages claim, we will assume, without deciding, that it would also apply to Blue Shield's claim for injunctive relief.[4]

The organized dentists correctly point out that many of their departicipation resolutions were adopted at meetings which occurred more than four years before March of 1982. In addition, they contend that many of the withdrawals from participation occurred more than four years before the date of filing of the counterclaim. As Blue Shield points out, however, its cause of action for damages accrued only when it suffered injury. *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 401 U.S. 321, 338 (1971). Moreover, each time a plaintiff is injured by a continuing conspiracy to violate the antitrust laws a new cause of action for damages accrues. *Id.* "[E]ach separate cause of action that so accrues entitles a plaintiff to recover not only those damages which he has suffered at the date of accrual, but also those which he will suffer in

4. *See* Farbenfabriken Bayer, A.G. v. Sterling Drug, Inc., 197 F.Supp. 627 (D.N.J. 1961), *aff'd*, 307 F.2d 210 (3d Cir. 1962), *cert. denied*, 372 U.S. 929 (1963).

the future from the particular invasion, including what he has suffered during and will predictably suffer after trial." *Id.* at 338-39 (citations omitted).

The summary judgment record as it now stands would permit a factfinder to conclude that the conspiracy charged by Blue Shield is a continuing one and that its effects continued well into the four-year period preceding the March, 1982 filing of the counterclaim. Most of the offending resolutions have never been rescinded. Blue Shield continues to encounter resistance to its participation contract traceable to the organized dentists' earlier actions. Additionally, there is evidence of overt acts in furtherance of the conspiracy occurring within the limitations period. Plainly, therefore, even if the four-year statute of limitations were deemed to be applicable to the claim for injunctive relief, that claim would not be time-barred. Furthermore, section 4 damages caused by any overt act taking place from March of 1978 forward may also be recovered. *See Hanover Shoe, Inc. v. United Shoe Machinery Corp.*, 392 U.S. 481, 495-502 (1968).

Thus, we must reject the organized dentists' contention that the statute of limitations on the present record affords an alternative legal ground for affirming the summary judgment in their favor. If further factual material is presented, the district court may, of course, reconsider the statute of limitations defense.

VII.

The summary judgment in favor of the organized dentists cannot be affirmed for the reasons on which the district court based its decision. No other basis for affirming a summary judgment appears in the record before us. The judgment appealed from, granting

summary judgment on the federal law claims and dismissing the pendent state law claims, must therefore be reversed and the case remanded for further proceedings.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

PENNSYLVANIA DENTAL ASSOCIATION, *et al.*, *Third-Party Plaintiffs*	:	CIVIL ACTION NO. 81-1187
v.	:	
MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, *et al.*, *Third-Party Defendants*	:	

MEMORANDUM

Before the Court and ripe for decision is the motion of the third-party counterclaim defendants[1] (referred to hereinafter as "the dentists") for summary judgment with respect to the third-party counterclaim of the third-party plaintiffs[2] (referred to hereinafter as "Blue Shield"). This Opinion addresses that motion.

The Commonwealth of Pennsylvania initiated this civil action on October 20, 1981, by filing a complaint against the Pennsylvania Dental Association (PDA) and a number of other dental associations, contending that these associations were violating antitrust laws, principally by encouraging dentists to

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1. The third-party counterclaim defendants are the Pennsylvania Dental Association, the Delaware Valley Dental Society, the Erie County Dental Association, Inc., the Harrisburg Area Dental Society, the Luzerne County Dental Society, the Montgomery-Bucks County Dental Society, the Odontological Society of Western Pennsylvania, the Scranton Dental Society, the York County Dental Society, the Fifth District Dental Society of the Pennsylvania Dental Association, Dennis W. King, D.D.S., Charles M. Ludwig, D.D.S., Theodore R. Paladino, D.D.S., Thomas L. Perkins, D.M.D., Kay F. Thompson.

2. The third-party counterclaim plaintiff is Pennsylvania Blue Shield.

terminate Blue Shield participating dentist agreements. The Association filed answers to the complaint on or about November 9, 1981.

On November 17, 1981, the PDA filed the third-party complaint at issue here naming, *inter alia*, Pennsylvania Blue Shield and Donald S. Mayes, D.D.S. as third-party defendants.

On March 11, 1982, after a motion to dismiss had been denied, Blue Shield filed its answer to the third-party complaint and its counterclaim against the dentists. The dentists moved to dismiss Blue Shield's counterclaim, which motion was denied by order of July 30, 1982. On September 20, 1982, the dentists filed a responsive pleading to Blue Shield's counterclaim, which included a class action counterclaim against Blue Shield and Dr. Mayes brought by PDA and three other dental associations.

On September 15, 1982, Blue Shield filed a motion for a preliminary injunction. On November 17, 1982, PDA filed a motion for a preliminary injunction. On December 30, 1982, both the motions of Blue Shield and of PDA for preliminary injunctions were denied.

On November 22, 1982, the Court granted a joint motion of the Commonwealth and the Dental Associations dismissing the initial complaint on the basis of a settlement agreement.

On January 25, 1983, the class plaintiffs filed a motion for class certification. On April 6, 1983, that motion was denied in part and granted in part, the Court denying class certification completely to one subclass and certifying another subclass for injunctive relief only. That order was appealed to the Third Circuit Court of Appeals on April 13, 1983. On April 26, 1983, Blue Shield and Dr. Mayes filed a motion to dismiss the appeal and on May 24, 1983, the appeal was dismissed.

On October 28, 1983, the Court addressed the dentists' third-party complaint and class action counterclaim against Blue Shield in this case, deciding that Blue Shield was entitled to summary judgment as to those claims. *Pa. Dental Assn. v. Med. Serv. Assn. of Pa.*, 574 F.Supp, 457 (M.D. Pa. 1983), *aff'd.*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, ____ U.S. ____ (1985). We now address the dentists' motion for summary judgment as to

Blue Shield's claims that the dentists and their associations have violated the antitrust laws.

In the third-party counterclaim, Blue Shield claims that the dentists have unlawfully restrained trade in violation of Section 1 of the Sherman Act by unlawfully combining and conspiring to boycott Blue Shield's dental health care plans, so as to discourage organizations from enrolling in Blue Shield's health care plans to stabilize fees for dental services, to interfere with Blue Shield's cost containment efforts and to influence Blue Shield policies. The complaint alleges that the dentists and their associations caused other dentists to cease being Blue Shield participating dentists, have agreed to raise, fix and stabilize prices, have communicated guidelines for dealing with Blue Shield, have encouraged dentists not to cooperate with Blue Shield audits, have encouraged dentists to increase fees for patients who have dental insurance and have attempted to coerce Blue Shield to change various provisions of its dental health care plans. Pendent state law claims are also raised by Blue Shield.

Extensive discovery has been completed and extensive documentation is submitted to the Court in connection with the dentists' motion for summary judgment.

The dentists have based their summary judgment motion upon the contention that there is no evidence of actionable antitrust injury. By Order of February 7, 1986, we ordered the parties to file supplemental briefs addressing as well the broader question whether the third-party counterclaim defendants' conduct violated the antitrust laws. We have now carefully considered all of the parties' evidence and arguments. We find that there are no material facts in dispute and that, crediting Blue Shield's viewpoint as to the inferences that can be drawn from all of the evidence to the extent that those inferences are reasonable, the dentists are entitled to summary judgment for the reasons which follow.

I. FACTS.

In Blue Shield's brief in opposition to the dentists' motion for summary judgment, Blue Shield has set forth a very lengthy

statement of the facts which it believes that it could prove at a trial of this case and which it contends would entitle it to relief under the antitrust laws.[3] Blue Shield Brief, November 27, 1985, Doc. 972, pp. 6-74. These facts may fairly be stated in a less lengthy fashion as follows:

The Medical Service Association of Pennsylvania does business under the registered fictitious name of Pennsylvania Blue Shield. Blue Shield is a non-profit corporation operating as a professional health service corporation under the laws of Pennsylvania providing for prepaid medical, osteopathic, psychological, optometric, podiatric, dental services, and certain other professional health services. Blue Shield was created in the late 1930s by representatives of the Pennsylvania Medical Society. The Pennsylvania Insurance and Health Departments regulate Blue Shield pursuant to the Professional Health Service Corporation Act, 40 Pa.C.S. §6301, *et seq.*, as amended (the Blue Shield Regulatory Act).

Initially Blue Shield programs were structured as fee schedule programs. Blue Shield provided benefits (called service benefits) to its subscribers through a participating doctor system whereby the vast majority of licensed doctors of various health-related disciplines agreed, *inter alia*, to be paid directly by Blue Shield in accordance with certain specified fee schedules for specified services. Doctors in Pennsylvania could participate with Blue Shield by signing a Participating Doctor's Agreement, whereby the doctors agreed to be bound, *inter alia*, by the Blue Shield Regulations for Participating Doctors. Subscribers were always free to use the services of non-participating doctors; however, in that case Blue Shield reimbursed the subscriber and not the doctor. Blue Shield programs were marketed only after approval by the Insurance Department in accordance with the Blue Shield Regulatory Act.

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3. Blue Shield, specifically "reserves . . . its right to set forth . . . additional portions of its case . . ." (Doc. 972, p.6). We are satisfied that Blue Shield has set forth a comprehensive statement of its probative evidence, however.

In accordance with the Blue Shield Regulatory Act and Blue Shield's By-Laws as determined by its corporate membership, if a subscriber was classified as under-income, participating doctors were required to accept Blue Shield's payment under the fee schedule for a covered service as payment in full. Also in accordance with the Blue Shield Regulatory Act, if a subscriber was classified as over-income, (also pursuant to Blue Shield's By-Laws and as determined by its corporate membership) the participating doctor was permitted to charge (balance bill) that over-income subscriber an amount in addition to the fee schedule amount paid by Blue Shield.

Under Blue Shield medical/surgical coverage, there was very limited coverage for dental services. The only dental services covered were oral surgical services (e.g. accident/trauma cases, impacted wisdom teeth extractions). An important segment of Blue Shield's business historically was group accounts, usually through employers, labor unions and/or government organizations. In the 1960s these groups began to demand a medical/surgical reimbursement system which could respond to the pressures of inflation yet maintain some reasonable controls over excessive professional charges. This led to Blue Shield's development of a concept of reimbursement of participating dentists by Blue Shield according to a formula which takes account of independently established charges or fees of competing practitioners with a cap at a percentile of usual charges of all practitioners in a similar geographic area and in a similar specialty. This mode of reimbursement is referred to as the UCR, denoting a reimbursement formula which Blue Shield has devised to result in a reimbursement to dentists that is usual, customary and reasonable. Generally, no distinction has been made between over-income or under-income subscribers in Blue Shield's UCR programs, although Pennsylvania law would have permitted such a distinction.

By the late 1960s, after obtaining Insurance Department approvals, Blue Shield widely marketed its medical/surgical UCR product together with Blue Cross hospitalization and Blue Cross/Blue Shield major medical coverage. Under Blue Shield's UCR programs, if a Blue Shield subscriber used the services of

a participating physician, the physician by his Participating Doctor's Agreement (as implemented by Blue Shield's Regulations for Participating Doctors) was not contractually permitted to balance bill, i.e. charge the subscriber the difference, if any, between the Blue Shield allowance for a covered service and the physician's charge. In addition, as authorized by the Blue Shield Regulatory Act, subscribers to Blue Shield's UCR programs were not permitted to assign their benefits.

In offering its medical/surgical and other programs, Blue Shield has competed in the marketplace with programs offered by commercial insurance companies. Blue Shield has also been in competition with employers which sponsor self-insured or direct pay programs.

The overwhelming majority of Pennsylvania's physicians are Blue Shield participating doctors. Blue Shield believes that a sufficient number of participating doctors is essential to the operation of effective service benefit programs for Blue Shield subscribers.

Employees in Pennsylvania with group medical/surgical, hospitalization and major medical coverage as employee fringe benefits began seeking other health benefits in negotiations with their employers. The health insurance industry viewed prepaid dental services as the next frontier to explore for employee benefit coverage. Blue Shield determined to meet this marketplace demand in Pennsylvania. In order for Blue Shield to meet these market demands, and be able to offer prepaid dental programs on a service benefit basis, Blue Shield had to rely upon strong participation and cooperation by the individual practitioners who comprised the dental profession.

In 1949, the Blue Shield Regulatory Act was amended to permit dentists to become participating doctors. At that time, the business aspects of the practice of dentistry were quite different than they are today. The average dentist had no one to answer to except the patient. There were no dental utilization review committees and other committees and processes like those with which physicians were confronted in the hospital

setting. Dentists were unused to dealing with insurance companies, the forms and the red tape. Physicians had grown up with the practice since the 1940s.

In the 1960s through the early 1970s, dentistry was still a cottage industry or profession; the profession was one of the last bastions of rugged individualism. Dentists had frequently engaged in sole practice with an office assistant or two and a hygienist. Dentists have placed a great value on the dentist-patient relationship and the traditional private practice, fee-for-service method of delivery of dental services. Traditionally, a direct financial relationship existed between the patient and the dentist. Because there was little or no dental insurance prior to the 1970s, natural market forces tended to influence dentists to charge what patients could afford and to perform only those services patients could afford.

In the late 1960s, the vast majority of Pennsylvania's dentists were members of the Pennsylvania Dental Association (PDA). Counterclaim defendant PDA is the Pennsylvania statewide affiliate of the American Dental Association. It is comprised of ten component districts. Counterclaim defendant Odontological Society of Western Pennsylvania (also known as the Dental Society of Western Pennsylvania) is the Tenth District component of the PDA. Counterclaim defendant Fifth District Dental Society is also a component of the PDA. The ten districts are in turn subdivided into a number of local societies. Counterclaim defendants Harrisburg Area Dental Society and York County Dental Society are local societies within the counterclaim defendant Fifth District Dental Society's geographic territory. Counterclaim defendant Erie County Dental Association, Inc. is a local society within the Ninth District of the PDA. Counterclaim defendants Luzerne County Dental Society and Scranton District Dental Society are local societies within the Third District of the PDA. Counterclaim defendant Montgomery-Bucks Dental Society is a local society within the Second District of the PDA. Counterclaim defendant Delaware Valley Dental Society is not directly affiliated with the PDA. The leadership of the PDA debated upon the role it wished the PDA to play with the advent of dental prepayment. PDA

created the Pennsylvania Dental Service Corporation, which does business under the name Delta Dental. Delta Dental was incorporated under the same regulatory act as Blue Shield.

In the late 1960s and the early 1970s, Blue Shield formulated plans for designing and marketing a prepaid dental program. Blue Shield believed that it needed the input of dentists to make its dental program feasible and successful. Blue Shield wanted to market its prepaid dental program on the basis of a participating dentist system. Blue Shield hired a practicing dentist to assist in the design, development and implementation of its prepaid dental program.

Blue Shield, the PDA and Delta Dental consulted with each other and for a time discussed implementing a joint program. This did not materialize and Blue Shield went its separate way. The PDA funded Delta Dental by a loan and Delta Dental has been in competition with Blue Shield ever since.

In 1969, the PDA's House of Delegates adopted a resolution known as H.D. 69-6, which states:

> "[t]hat any not for profit corporation when contemplating a dental program follow the Association's [PDA's] direction and advice in designing and implementing such a program . . . that in the absence of such cooperation the Association [PDA] will vigorously inform its members of such lack of cooperation, pointing out to them the intrinsic dangers that are likely to ensue by participating in such programs. The [PDA] will exert all efforts to prevent the approval by the Insurance Department of such service benefit contracts."

That resolution was rescinded in May or June of 1978.

Blue Shield's dental program was designed to be marketed on a group-only basis using the participating dentist, UCR concept. The prototype group dental policy, called PennDental I, was submitted to and approved by the Insurance Department of Pennsylvania in 1970. In 1970, Blue Shield also submitted its prototype group dental policy to the PDA for its review. In June of 1970, PDA President Dr. Willis McCormick informed Blue

Shield that the PDA was satisfied with the proposed design and implementation of Blue Shield's dental plan and saw no reason to file objections with the Insurance Department at that time.

As of June, 1970, Blue Shield perceived everything to be coming up roses. Joint discussions between Blue Shield, the PDA and Delta Dental were still taking place. Blue Shield had not yet sold any groups, but Blue Shield service representatives were signing up participating dentists. Dentists were signing the participating doctor's agreement, agreeing to treat Blue Shield subscribers and to be bound by Blue Shield's regulations for participating doctors. Among the specific matters that dentists agreed to upon participation were (1) to refrain from balance billing, (2) to permit Blue Shield to examine their patient records (audit), and (3) not to charge Blue Shield subscribers more than their usual charges. The Blue Shield prepaid dental program also prohibited assignment of a subscriber's right of payment.

Blue Shield believed that in order to have an effective marketing effort, it should sign up about 70% (or more) of the state's dentists, as participating dentists, which Blue Shield accomplished by mid-1974. Blue Shield sold its first group dental program in January, 1972. Meanwhile, Delta Dental and the commercial insurance companies were also marketing prepayment programs in competition with Blue Shield.

The advent of prepayment coverage changed the way dentists were being paid for their services. Before there was a dentist-patient relationship only. Third-party payment caused some dentists to provide a broad range of services to people who never before had extensive dental services. Some dentists were tempted, because patients had insurance, to charge more, to prescribe a broader range of treatment and to provide more costly services when less expensive services would have sufficed.

Prepaid dental programs are not really insurance. Dental disease is practically univeral and the use of services by individuals occurs at a rate in excess of 50% of the individuals in a prepaid dental group per year. The average claim amount is usually less than several hundred dollars. Much dental care can

be postponed almost indefinitely, and since there is a wide range of treatment choices availabe to the dentist and the insured, the choice of treatment alternatives creates an uncertainty in benefit amount (e.g., the choice of gold versus amalgam fillings or extractions and bridges versus root canal and crowns). Claim expenses are high at the inception of coverage, because there is usually a backlog of unmet needs that result from neglect and disease before the effective date of insurance. Prepaid dentistry is more like a pooled budgeting mechanism than true catastrophic indemnity insurance. A viable dental program must combine common medical insurance concepts with some new mechanisms. Some of these mechanisms are, in addition to the participating doctor arrangements, direct payments to participating doctors, no balance billing, medical necessity and a prohibition against assignment of benefits. New mechanisms introduced by the dental program included the concept of predetermination, the less costly but adequate treatment alternative and a provision for excepted dentists (i.e., a group of dentists excepted from Blue Shield's auditing requirements).

Blue Shield believes that for a UCR system to operate effectively, it must be based upon a uniform usual charge submitted by a practitioner for reimbursement. A two-tiered charge structure whereby a practitioner charges his uninsured patients a lower fee for a service than his insured patients makes the UCR reimbursement system less economical, less workable and less marketable for Blue Shield. Blue Shield asserts that many dentists in Pennsylvania have been charging their insured patients more than their non-insured patients.

Despite the PDA's initial approval of the Blue Shield proposed dental program in 1970, dentists in this cottage industry had some misunderstandings about Blue Shield's dental program. Such misunderstandings filtered up to organized dentistry which reacted in different ways across the state and across the country. Some dentists objected to a perceived intrusion of third-party carriers, particularly service corporations like Blue Shield and Delta Dental, in their practices. Those dentists wished to preserve the traditional relationship between dentist and patient. The traditional school of thought

believed it best not to participate contractually with Blue Shield or Delta Dental. Blue Shield believes that the motivation of these dentists was principally economic, although these dentists cited health factors in their opposition. Blue Shield asserts that these dentists wanted to maintain the traditional economic relationship between dentist and patient, yet obtain direct payment from insurance companies pursuant to an assignment of the patients' benefits to the dentist and that these dentists believed that carriers such as Blue Shield, Delta Dental and commercial insurance companies should merely be conduits for funds. These dentists did not wish to be second-guessed in their diagnoses and treatment of patients, nor did they want to submit diagnostic aids such as x-rays and study models to be scrutinized by insurance carriers. Blue Shield acknowledges that part of this school of thought was philosophical — dental professionals did not want third parties to intrude into traditional areas of dental practice — but asserts that the dentists' objections were primarily economic. Blue Shield asserts that traditional dentists believed they could collectively dictate the terms on which they would deal with third-party carriers if all or a majority of dentists refused to cooperate with Blue Shield and Delta Dental.

A confrontation ensued between the dentist-traditionalists and third-party carriers seeking to implement sufficient but reasonable cost containment mechanisms. Blue Shield and other insurance companies viewed themselves as more than mere financial intermediaries. Blue Shield considered itself to represent subscribers as bargainers of quality and cost of treatment. Blue Shield's marketing to employer groups is premised on this concept. Blue Shield perceived itself as a substitute agent in an economic sense for its subscribers. Some dentist-traditionalists viewed this role as an unwarranted intrusion into the traditional dentist-patient relationship.

On September 9, 1974, the Executive Board of the Erie County Dental Association, Inc. (ECDA), a counterclaim defendant, recommended that the ECDA membership drop participating doctor relationships. On September 12, 1974, the ECDA adopted a resolution opposing the concept of participating dentists and recommended that its members withdraw from any

list of participating dentists and render services only as non-participating dentists.

Counterclaim defendant Charles Ludwig, D.D.S. holds himself out as an expert in dental prepayment, and has published on the topic of self-insurance. Dr. Ludwig is a member of the Harrisburg Area Dental Society (HADS) and was trustee of the Fifth District Dental Society to the Pennsylvania Dental Association for a number of years. Dr. Ludwig is the PDA's President-elect. In October of 1974, counterclaim defendant Harrisburg Area Dental Society published a document called its Dental Insurance Manual, which was disseminated to dentists and others statewide and beyond. Dr. Charles Ludwig was an author of the manual. Dr. Ludwig also extensively lectured on the topic of prepayment. He and the HADS Dental Insurance Manual have persistently advocated non-participation with third-party payers, have advocated a uniform and unified position of organized dentistry with respect to third-party payment, and have opposed submitting any diagnostic aids such as x-rays or study models to any third-party payers to substantiate claims for payment.

On October 3, 1974, counterclaim defendant Fifth District Dental Society, which includes as components local dental societies including counterclaim defendants HADS and York County Dental Society, adopted a resolution recommending to its membership that they avoid contractual relationships with third parties and not sign contracts or agreements implying or registering them as participating dentists. The Fifth District Dental Society's resolution of October 3, 1974 has not been rescinded. The Fifth District's resolution led to mass resignations from Blue Shield participation among dentists in the Fifth District of the PDA and Blue Shield still suffers from the effects of such resignations today.

A number of dentists from the HADS, including Dr. Ludwig, visited counterclaim defendant Scranton District Dental Society in November of 1974 and spoke to the Scranton Society expousing their traditional views against participation with Blue Shield (and Delta Dental). At the Scranton meeting, the Scranton District Dental Society adopted a resolution that

its members should not sign contractual agreements with third parties registering them as participating dentists. The resolution led to mass resignations from Blue Shield participation in the Scranton area. That resolution has not been rescinded.

Counterclaim defendant Luzerne County Dental Society passed a resolution in December of 1974 requesting its members to become non-participants in the Blue Shield dental program. That resolution is still in effect. That resolution led to mass resignations in the Luzerne County area.

In December of 1974, HADS adopted a resolution that its membership should avoid contractual agreements with third parties and should not sign contracts or agreements registering them as participating dentists in a program. Dr. Charles Ludwig introduced that resolution. In addition, a written pledge was circulated at the HADS' December, 1974 meeting pledging that the dentists-members of the HADS are non-participating dentists in any third-party program or that they will resign from such contractual participation. Following the HADS' departicipation resolution, many dentists resigned as Blue Shield participants.

The HADS held meetings with dentists and attempted to persuade the HADS membership into departicipation on a more individual basis. There is no evidence of any coercion, nor any evidence that participating dentists had any reason for concern about any negative effects of exercising independent judgment about participating with third-party insurers.

Blue Shield used outside dental consultants and advisors for its dental program and had developed a quality assurance program at the urging of the then Pennsylvania Insurance Commissioner, Herbert Denenberg. Early in 1974, the PDA objected to Blue Shield's publication of lists of participating dentists. In the fall of 1974, the PDA sponsored a series of workshops for dentists on the topic of dental prepayment programs. At a workshop held on October 23, 1974, there was a great amount of discussion regarding participation with Blue Shield. The majority of those present opposed participation with Blue Shield and suggested that the PDA seek a meeting with officials of Blue Shield. The PDA invited officials of Blue Shield

to attend the December 12, 1974 PDA Board of Trustees meeting in Harrisburg. Dr. Booth, the PDA President, told Blue Shield representatives at the meeting that the PDA had many areas of concern with Blue Shield but most important was the "contractual agreement, or participation, that [Blue Shield] use[s] to control dentists." He stated that PDA members statewide were disturbed by Blue Shield practices as evidenced by the then recent Scranton area mass resignations. He stated that the PDA membership had complained of preauthorization (also known as predetermination), the operation of the UCR system and the distribution of lists of participating doctors, all of which concepts were not in the best interest of patients and of dentistry's efforts to deliver *optimal* dental care. He remarked that unless Blue Shield and the PDA could come to a reasonable resolution of these disputes, he and the other PDA Trustees would have no alternative but to resign their participation with Blue Shield and inform the PDA membership of the reasons for their resignations. Dr. Booth's remarks were set forth in the minutes of the December 12, 1974 PDA Trustee's meeting and were also reported verbatim to some dentists.

In subsequent communications PDA representatives objected to the requirement that participating doctors accept Blue Shield's allowance as payment in full for covered services; to the rule that Blue Shield subscriber-patients of non-participating doctors could not assign their benefits and to Blue Shield's provision for preauthorization (predetermination). Blue Shield declined to change the fundamentals of the way Blue Shield was conducting its dental program.

In his address to the 1975 PDA House of Delegates Annual Meeting, Dr. Booth summarized PDA's objections to Blue Shield's dental program and expressed the hope that the negotiation process with Blue Shield would persuade Blue Shield to make changes.

At the January, 1975 installation of officers of counterclaim defendant HADS, HADS' incoming President Bubeck, as part of his inauguration address, urged all HADS members who had not yet resigned (from Blue Shield and Delta Dental) to do so, citing as the principal reason that the dentists should not come

under the control of a third-party insurance company as to either fees to be charged or treatment decisions. Dr. Burbeck noted that insurance companies accused dentists of incompetency and dishonesty in an effort to win support for their role as a monitor of the quality of dental care, and proposed that dentists retain control over the matter of quality of care by self-regulation within the profession.

Counterclaim defendant York County Dental Society passed a resolution in 1975 that its membership should not be participating members of any third-party prepayment program. That resolution has not been rescinded. More than 85% of the general dentists in the York County area sent in letters of resignation to Blue Shield.

In April 1975, counterclaim defendant Montgomery-Bucks Dental Society passed a resolution urging its members to resign from participation with Blue Shield, because of Blue Shield's efforts to control fees and treatment decisions. That resolution has not been rescinded. Resignations from Blue Shield participation ensued in that area.

In the spring of 1975, counterclaim defendant Dr. Charles Ludwig traveled to Erie, Pennsylvania to address the membership of counterclaim defendant ECDA, giving his views on participation with Blue Shield. In 1975, the ECDA reaffirmed its September 12, 1974 departicipation resolution. Resignations from Blue Shield participation in the Erie area occurred. The ECDA's position regarding non-participation was reaffirmed again in the 1980s.

In 1975, the PDA House of Delegates adopted new Standards for the Design of Prepayment Programs. Those Standards were renamed Guidelines in 1978. They are still in effect. They include, *inter alia*:

> Standard No. 5. There shall be no administrative, promotional or educational policies adopted which interfere with the dentist-patient relationship.

Standard No. 6. Contractual agreements between dentists and carriers which compromise or interfere with the dentist's ability to provide optimal dental care should be avoided.

Standard No. 7. Diagnosis and treatment planning shall remain the exclusive prerogative of the attending dentist. Preauthorization by the carrier shall be limited to predetermination of the insured patient's eligibility and the extent of benefits provided by the program.

Diagnostic materials are not required in this determination.

Standard No. 14. The program shall have a provision for the assignment of the patient's benefits to the dentist.

The percentage of Blue Shield participating dentists statewide as compared to all dentists who submitted claims to Blue Shield declined from in excess of 72% in 1974 to less than 54% in the early 1980s. Blue Shield claims that the decline in the numbers of participating dentists harmed Blue Shield's marketing efforts statewide, particularly in certain areas, such as northwestern Pennsylvania (the Erie area), central Pennsylvania (Fifth District, HADS, York County, etc.) and northeastern Pennsylvania.

The President of the Fifth District Dental Society in 1981 lectured a Hanover Dental Society meeting to the effect that no one should participate with Blue Shield and that if no one participates, Blue Shield would not be able to sell its insurance programs.

The PDA rejected a Blue Shield advertisement which Blue Shield attempted to place in the PDA's official publication, the Pennsylvania Dental Journal, by which Blue Shield sought to encourage dentists to participate with Blue Shield. The Journal is the official publication of the PDA. It is the only statewide periodical for dentists.

In 1978, the HADS sought and obtained an opinion of counsel (Mr. Beckley) who reviewed the HADS Dental Insurance Manual. Acting upon Mr. Beckley's advice, HADS passed

a resolution suspending all policies and guidelines regarding third-party programs. Blue Shield attributes this development to an apprehension among some dentists that their policies might be in violation of antitrust law principles. The suspension resolution of HADS was not distributed to all dentists. No effort was made to nullify the effects of the HADS 1974 departicipation pledge. While gradually more dentists from HADS have participated with Blue Shield, the percentage of their participation has never reached the pre-1975 level of participation. All of the other societies and associations in this case still have their departicipation resolutions or recommendations of record.

In 1978, Esther Richwine, the PDA Executive Director, stated publicly that due to concerns regarding the FTC, Mr. Beckley, PDA counsel, was auditing the minutes of the PDA.

Commencing in 1977, the PDA began to challenge and protest virtually every filing made by Blue Shield with the Insurance Department or the Health Department which involved or affected Blue Shield's dental program and initiated a number of court proceedings against or involving Blue Shield. Blue Shield asserts that the purpose of these challenges, protests and legal actions was to coerce Blue Shield to change its business practices so as to reduce price competition among dentists and to preserve the private practice fee-for-service method of financing dental services.

Blue Shield initiated an in-office review program (IOR). The PDA advised its membership on how to deal with Blue Shield audit requests. The PDA developed two types of audit forms letters — one for participating dentists and one for non-participating dentists. Since 1977, the PDA has advised dentists that disclosing non-insured patient records to Blue Shield during an IOR might be an invasion of the patient's right to privacy. Many dentists did not permit Blue Shield to verify that they were not charging Blue Shield more than their usual charges. The PDA also sent observers to attend audits and developed written guidelines (to which insurers were asked to adhere) with respect to audits.

PDA's audit advice to dentists caused some dentists to believe that they should not disclose non-insured patient

records as part of Blue Shield's IORs. This impaired Blue Shield's IOR program.

Blue Shield believes that many dentists have been overcharging Blue Shield by charging Blue Shield subscribers more because they have insurance. A number of dentists have resigned upon being notified of an audit by Blue Shield and a large percentage have refused to disclose their non-insured patient records.

Conterclaim defendant Theodore R. Paladino is a lawyer as well as a dentist. As an attorney, he has represented dozens of dentists regarding Blue Shield audits and has represented some dentists before Blue Shield's dental review committee. Dr. Paladino consistently has advised his clients that he questioned Blue Shield's authority to audit them and that they were not obligated to disclose non-insured patient records to Blue Shield.

Blue Shield sought the Department of Health's approval to amend its regulations for participating doctors a number of times to eliminate the basis for some of the objections being raised by Dr. Paladino and the PDA as to Blue Shield's right to audit and inspect records. Blue Shield sought to amend its Regulations for Participating Doctors before the Department of Health regarding its procedure for verifying usual charges, and Dr. Paladino and the PDA filed objections. The Fifth District Dental Society (and Dr. Ludwig) also commented negatively on Blue Shield's effort to amend its Regulations for Participating Doctors regarding verification of usual charges. The Department of Health approved verification of usual charges (by inspecting non-insured patient records), thus expressly permitting Blue Shield to examine non-insured patient records provided that the identities of such patients were concealed. PDA unsuccessfully appealed such approval to the appellate courts of Pennsylvania.

Blue Shield views dentists' resistance to its IORs as a concerted effort by the dentists to cover up potential fraud and abuse.

Some of the dentists supported a resolution in the Pennsylvania legislature. They inspired House Resolution 15, adopted by the Pennsylvania House of Representatives in March

1981, which called for the scrutiny of health service corporations operating under the Blue Shield Regulatory Act.

House Representative Charles Laughlin from Aliquippa, Beaver County, Pennsylvania is a patient and friend of Dr. Gerald Kolavic. Blue Shield had audited Dr. Kolavic, who was also one of Dr. Paladino's clients, and he was found to have improperly overcharged Blue Shield.

In 1980, counterclaim defendant Odontological Society of Western Pennsylvania formed a committee consisting of predominantly dentists. Commencing in 1980, the committee held a number of meetings. There was a meeting held on June 20, 1980 in Sewickley, Pennsylvania. Counterclaim defendants Drs. Ludwig, Paladino and Perkins attended and participated at this meeting. During the meeting, some of the dentists told a member of the Pennsylvania House of Representatives who was present that Blue Shield interferes with dentist-patient relationships by limiting certain coverage and that the only third-party payer causing problems for dentists and consumers is Blue Shield.

Another meeting concerning Blue Shield was held in Pittsburgh on November 13, 1980. More than 300 dentists attended the meeting. At the November 13, 1980 meeting, someone stated that it was permissible to charge a higher fee if a patient had insurance so long as more than half of a dentist's practice consisted of insured patients. Statements were also made at that meeting that there were not many Blue Shield participating dentists compared to the number of dentists in the state and that dentists, through resignation *en masse*, could force Blue Shield to deal with dentists on the dentists' terms.

During the November 13, 1980 meeting some of the dentists told a member of the House of Representatives who attended that sooner or later, all Blue Shield participating dentists will be audited by Blue Shield, that Blue Shield always asks for a refund after conducting an audit, that Blue Shield had, to that date, conducted 600 audits, that a dentist's usual charge would be reduced if he charged less to patients such as clergyman and relatives, and that third-party carriers cheat patients.

As a result of the adoption of House Resolution 15, as noted, *supra*, the House Consumer Affairs Committee held several hearings throughout the state to ascertain if the Blue Shield Regulatory Act should be amended. Counterclaim defendants Thompson, Ludwig, Paladino and Perkins (and others) were involved in much of the anti-Blue Shield testimony presented at these legislative hearings. Subsequent to the hearings a number of legislative bills were introduced by dentists which largely sought to amend the Blue Shield Regulatory Act in ways which would significantly change Blue Shield's dental program. The legislation would have permitted the assignment of benefits to dentists and would have turned Blue Shield claims disputes over to a PDA-controlled Peer Review System; would have required the Blue Shield Dental Review Committee to hold hearings for adjustments of individual claims; and would have required Blue Shield to update dentists' profiles even though Blue Shield suspected fraud.

In 1980 Blue Shield sought the approval of the Departments of Health and Insurance to implement an experimental dual choice capitation program for employees of the Fairless Hills Works of U.S. Steel located in the Levittown/Fairless Hills suburbs of Philadelphia.[4] This capitation program was known as DentalPLUS. Some of the counterclaim defendants, including PDA, protested these filings. Both Departments approved Blue Shield's DentalPLUS filings.

The PDA appealed to the Commonwealth Court and to the Supreme Court of Pennsylvania. These protests delayed implementation of the DentalPLUS and other Blue Shield capitation programs. Blue Shield contracted with two dental offices to act as dental capitation centers to provide dental services to DentalPLUS subscribers and obtained a verbal commitment from the University of Pennsylvania to likewise participate as a dental capitation center for DentalPLUS.

A group of dentists, most of whom were members of the counterclaim defendant Montgomery-Bucks Dental Society,

4. A capitation program provides for treatment by a specific group of physicians for the insured patients.

formed an unincorporated association which they called the Delaware Valley Central Society to compete with DentalPLUS.

The PDA Central Office provided form letters for Delaware Valley Dental Society dentists to send to their patients soliciting their choice of that Society over DentalPLUS. Delaware Valley Dental Society successfully pressured the University of Pennsylvania to withdraw from the Blue Shield DentalPLUS program. DVDS members also contacted Temple University School of Dentistry to dissuade Temple from participating in DentalPLUS and encouraged steelworkers not to enroll in the Blue Shield DentalPLUS capitation program. At its 1981 Annual Meeting the PDA House of Delegates adopted a resolution which stated that the PDA was not in favor of capitation programs.

PDA's Council on Dental Care Programs developed a Dental Prepayment Guide to give dentistry's point of view to prospective purchasers of prepaid dental programs in Pennsylvania. The Dental Prepayment Guide was designed to be used with the Dentists' consulting service to advise Pennsylvania companies on the types of programs available and to educate them "on what is a good program and what is not." The PDA Council disseminated the Dental Prepayment Guide to thousands of companies statewide.

The PDA also developed a purchaser contact program to train a cadre of 50 or more dentists statewide. The PDA's consulting service used the PDA's Standards for Dental Prepayment Programs and its Guidelines for Dental Prepayment Programs as criteria to determine what was, or was not, a good program. Blue Shield's dental programs did not comport with PDA's Standards or Guidelines.

Dr. Booth, former President of the PDA became an expert on prepayment programs and became an advisor to PDA's Council on Dental Care Programs and actively participated in seminars and workshops on how to train this 50-dentist purchaser contact cadre. Booth visited a representative of the United Steelworkers of America and an official of the United States Steel Corporation (these were and are existing Blue Shield accounts) in 1981 and made statements to those accounts

to the effect that Blue Shield rarely pays for crowns and that Blue Shield makes arbitrary administrative decisions.

An August 9, 1979 internal PDA memorandum contains an indication that PDA member dentists discussed Blue Shield coverage with Blue Shield accounts. A member of counterclaim defendant Odontological Society of Western Pennsylvania sent a letter to colleagues urging them to contact Blue Shield's existing accounts and urge those accounts to drop Blue Shield and pick up other coverage when the time came to renew coverage.

In 1977, counterclaim defendants ECDA formed a committee known as its Ad-Hoc Committee for the purpose of investigating professionalism, free enterprise and comraderie.

The ECDA held a series of workshops in 1980-1981 which were attended by about 120 out of the approximately 170 members of the ECDA. The ECDA prepared a special supplement to the PDA's Dental Prepayment Guide. This ECDA Dental Prepayment Guide Supplement was used to assist the Dental Care Committee of the ECDA in contacting prospective purchasers of dental prepayment programs in the Erie area. That practice operated to disparage Blue Shield's dental program. For example, the ECDA Supplement stated that a carrier's in-office accounting review services can only be carried out in an area where all dentists are participating.

ECDA representatives met with prospective purchasers of dental insurance in the Erie area and gave presentations which Blue Shield perceives to have been unfairly slanted against it.

Counterclaim defendants ECDA, Dr. Charles Ludwig and the Fifth District Dental Society have made statements in recent years to the effect that Blue Shield misleads prospective purchasers in areas where there is low Blue Shield participation as to its service benefit feature because paid-in-full dental service benefits are not available if there are not many participating dentists.

Representatives of counterclaim defendants York County Dental Society, Scranton Dental Society and HADS have similarly visited accounts and prospective accounts of Blue Shield.

Some of the dentists have promoted the concept of self-insurance or direct payment programs to combat Blue Shield. Dr. Ludwig has written on the topic of promoting the concept of self-insurance and he is engaged in a personal private enterprise of conducting business as a consultant in self-insurance and direct payment.

II. DISCUSSION

Summary judgment in an antitrust case is to be sparingly granted, particularly if it appears that there are factual questions presented as to the motive and intent of alleged conspirators, *Poller v. Columbia Broadcasting*, 368 U.S. 464, 82 S.Ct. 486, 7 L.Ed.2d 458 (1962). "Trial by affidavit is no substitute for trial by jury which so long has been the hallmark of 'even-handed justice.' " *Poller, supra*, at 473, 82 S.Ct. at 491. Here there is no demand for a jury trial. The same theories and evidence which would be presented to the Court at a non-jury trial are now before the Court in the context of the motion for summary judgment.

An antitrust case, like any case, is subject to analysis under F.R.C.P. 56 and summary judgment is appropriate if there are no material facts in dispute. ". . . [A]ntitrust litigation, if made immune from summary judgment, could become an anticompetitive activity itself . . . we should use summary dispositions to dispose of antitrust complaints that lack any significant supporting evidence." *Klamath-Lake Pharmaceutical Assn. v. Klamath Medical Service*, 701 F.2d 1276 at 1281-1282 (9th Cir. 1983). When there are not credibility issues impacting upon the determination of material factual questions, when the decision of the case boils down to drawing inferences from a history of events which is not materially in dispute, when all of the material evidence is before the Court, and when no jury trial is demanded, there is scant reason to defer decision of the issues presented until a trial has been held.

A. SHERMAN ACT, SECTION ONE.

The two basic elements of a cause of action under Section 1 of the Sherman Act are, first, that the defendant(s) entered into a contract, combination or conspiracy and, second, that the contract, combination or conspiracy restrains trade. *Sitkim Smelting & Refining Co. v. FMC Corp.*, 575 F.2d 440 (3d Cir. 1978); *Medical Arts Pharmacy v. Blue Cross & Blue Shield*, 518 F.Supp. 1100 (D. Conn. 1981). The United States Supreme Court, early in the history of the Sherman Act, interpreted the Section 1 prohibition to require an analysis addressed to the reasonableness of a trade restraint, since virtually all contracts can be viewed to restrain trade in some respect. *Standard Oil Co. v. United States*, 221 U.S. 1, 31 S.Ct. 502, 55 L.Ed. 619 (1911). While some business practices, such as horizontal price fixing among competitors, have been judicially determined to be unreasonable *per se* "because of their pernicious effect on competition and lack of any redeeming virtue," *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958), the categories of *per se* antitrust violations are narrowly and carefully defined, and most allegations that particular business practices constitute antitrust violations are to be analyzed under the "rule of reason." Under this rule, the essential analysis is whether the practice in question is anticompetitive. See, *National Society of Professional Engineers v. United States*, 435 U.S. 679, 688, 98 S.Ct. 1355, 1363, 55 L.Ed.2d 637 (1978).

> . . . not every agreement that has an impact on price, either vertically or horizontally is a *per se* violation of the Sherman Act. *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 23, 99 S.Ct. 1551, 1564, 60 L.Ed.2d 1 (1979). For example, a contract for the sale of goods 'fixes' the price at which the goods are to be sold, but such a contract is not *per se* illegal, absent a showing of some adverse impact on competition. *Cf. United States v. Topco Associates Inc.*, 405 U.S. 596, 606, 92 S.Ct. 1126, 1133, 31 L.Ed.2d 515 (1972); *Chicago Board of Trade v. United States*, 246 U.S. 231, 238, 38 S.Ct. 242, 243, 62

L.Ed. 683 (1918). The proper inquiry, thus, is not whether a particular agreement literally fixes a price, but whether the agreement is so 'plainly anticompetitive' and so very likely without 'redeeming virtue' that a court will apply the label '*per se* price fixing.' *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., supra*, 441 U.S., at 8-9, 99 S.Ct. at 1556-1557.

Blue Shield seeks by this antitrust action to have the Court consider in one civil action an extremely broad range of incidents, statements, policies, practices and issues.

However, the essence of Blue Shield's claim is that the dentists conspired to boycott Blue Shield's participating dentist program and thereby to harm Blue Shield as a seller of dental insurance. An analysis of Blue Shield's claim can not go forward under antitrust cases and principles without deciding first what market or markets are involved here and what relationship the dentists and Blue Shield bear to each other in the context of those markets.

1. RELEVANT MARKET.

We begin with the most obvious market, the market in which dental services are sold by dentists. In this market, dental services are purchased by individuals who need dental services, but in this market dental services are also purchased by suppliers of prepaid dental services such as Blue Shield, who buy dental services in bulk pursuant to the "participating dentist" program and sell them to the individuals insured under their insurance policies.[5] This market we identify for purposes of this Opinion as Market I.[6] Blue Shield can not logically or reasonably

5. When insured dental patients buy dental services from dentists in this market, pay the dentist directly, and receive reimbursement from the insurance company, the insurance company is not a purchaser of dental services.

6. Blue Shield considers this to be the relevant market for purposes of this case.

". . . [A] Blue Shield plan's status as a buyer and providers' status as sellers of services is basic to the application of the antitrust laws to health care reimbursement, *Group Life & Health Insurance Co.* v. *Royal Drug*

claim to be the victim of a boycott in Market I. There is absolutely no evidence, or even any suggestion, that in Market I the dentists ever were or ever would be unwilling to sell dental services to Blue Shield on the same terms as and at the same price as dental services are sold by the dentists to every other purchaser in that market. The fact is that Blue Shield is not offering to buy dental services at the same price and under the same conditions as other purchasers. It seeks to impose a host of conditions upon its purchase of dental services in Market I. It seeks compliance on the dentist's part with audits, predeterminations of treatment plans subject to Blue Shield's approval, and a lot of other things from the dentist that the dentist does not dispense to his other patients. In some instances, depending upon the dentist's usual fee and the result of Blue Shield's UCR calculation, it seeks to have the dentist sell his services to it at a discount. No principal of antitrust law or of free trade requires the dentists to sell their services to a particular purchaser at a discount or under terms and conditions not applicable to other customers. We think that our analysis of this case might very well end at this point, particularly when Blue Shield itself deems Market I to be the relevant market, since there is no evidence that the dentists have sought to or have fixed prices in Market I. See, pages 45-47, below.

In our Order of February 7, 1986, we suggested that another market may be the relevant market here, the market in which Blue Shield sells and dentists buy Blue Shield's "participating dentist" status. We will call this Market II. Blue Shield submits that this characterization is in error, in part because for purposes of the dentists' claims we perceived the principal relevant market to be the market in which dental services are

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Co., 440 U.S. 205, 214 (1979). See also, *Maricopa, supra; Va. Academy of Clinical Psy.* v. *Blue Shield of Va.*, 624 F.2d 476, 480, 483 (4th Cir. 1980). Blue Shield pays for services rendered its subscribers, either to the par dentist or the subscriber, and the dentist receives payment for his services. The essence of the parties' relationship and their dispute revolves around Blue Shield's terms and conditions of payment and the Dentists' collective opposition thereto."

Blue Shield brief, Doc. 983, pages 13-14.

sold. We find there to be no requirement in law or in logic that, for purposes of different claims by different parties, different markets may not be considered. Furthermore, we think that the evidence establishes quite clearly that the dentists' disagreement with Blue Shield and their departicipation goes not to Blue Shield's presence in Market I as a buyer of dental services, but rather to Blue Shield's presence in Market II as a seller of "participating dentist" status.

Blue Shield also appears to assert that the characterization of the relevant market is irrelevant to the legality of the dentists' boycott. We do not think so. On the contrary, we think that Blue Shield's failure to identify the relevant market has resulted in Blue Shield having no clear and discernible theory of its case and in a profusion of arguments and theories on Blue Shield's part, none of which is clearly rooted in established antitrust principles. We will, however, address these theories to the extent that it is possible to do so.

2. BOYCOTT BY DENTISTS OF BLUE SHIELD.

The Sherman Act prohibits conspiracies and combinations in restraint of trade, including boycotts and concerted refusals to deal. Blue Shield is not a buyer on equal terms with other buyers of dental services in Market I, and thus any concerted refusal on the dentists' part to deal with Blue Shield on its terms is not a boycott of a buyer in Market I, the relevant market. And there is no evidence that the dentists could or would want to affect Blue Shield's success in the market place as a vendor of dental insurance so long as individual dentists' fees were not affected and dentists were not required to submit to audits, peer review and all of the other conditions incidental to "participating dentist" status. There is, on the other hand, no doubt that the dentists have the capacity to affect, by concerted action, Blue Shield's success as a seller of fixed rate prepaid dental services policies which have the feature that the insured patient, so long as he goes to a participating dentist, will not have to pay any additional sum for covered services.

We have closely reviewed Blue Shield's evidence. We preface our discussion of the boycott issue with the following observations.

1. We have no evidence presented that Market I is not a free market. There is no evidence of aberrations of supply or of demand and no evidence that dentists do not, on an individual dentist-by-dentist basis, set and charge fees on the basis of such appropriate factors as the individual dentist's skills, the complexity of the service and the volume of patients seeking the dentist's services.

2. There is no evidence presented that the purpose or the effect of the dentists' departicipation was to fix dental fees or to stabilize them. Although Blue Shield contends in a conclusory fashion that this is the purpose and effect, there is no evidence of it. Blue Shield infers it from the fact that its rate of payment to participating dentists is generally lower than the fee those dentists otherwise charge. But if Market I is a free market, Blue Shield's inference is unreasonable. The reasonable inference is that already stated herein: Blue Shield is not truly a buyer of dental services in Market I because it will not pay the market price in that market.

In this regard, we note and distinguish the FTC decision in *Michigan State Medical Society*, upon which Blue Shield relies. Opinion appended to Doc. 983. There, the concerted conduct of the physicians was aimed at raising Blue Cross/Blue Shield reimbursement rates, and therefore the objective of the physicians' boycott was to affect and raise prices. There is no such evidence here. Here, the evidence plainly reveals that the dentists' efforts over the years was directed at preserving a traditional fee-for-services relationship between dentist and patient and against the participating dentist concept. Here, at best, Blue Shield's case is that the dentists conspired among themselves to be, each of them, independent economic entities in Market I. They conspired not to march to the same drummer by way of the participating dentist concept. They conspired and acted in concert, if anything, to preserve a market which the facts do not show to be anything other than a free market.

3. There is no evidence here of any coercive conduct on the dentists' part. There is abundant evidence that they sought to persuade, as individuals and as associations. They resolved, as groups of dentists in their associations, not to be participating dentists. Some communicated the message, in lectures and otherwise, that their concerted action could serve to destroy the "participating dentist" approach to the practice of dentistry. But there is no evidence that they devised or communicated any sanctions that they would take against other dentists, other entities or other persons if their message was not accepted. Thus, this case is distinguished from, for example, *American Medical Association v. United States*, 317 U.S. 519 (1943),[7] in which doctors and their associations devised a scheme of sanctions against other doctors and hospitals for participating in a risk-sharing prepayment plan for the rendering of medical services.

4. It must be inferred from the evidence that the dentists and associations were not speaking and acting with respect to Blue Shield as an entity, although frequently they referred to Blue Shield as the embodiment of their bone of contention; in fact, their bone of contention and the object of their resolutions and concerted action was the concept of practicing dentistry under the "participating dentist" system.

Blue Shield's evidence is not that the dentists conspired against Blue Shield as an entity. They objected to a concept — participating dentist status — and the impact of that concept upon the practice of dentistry. In some respects and in some instances, the more or less collective reasoning of many of the dentists, that participating dentist status was undesirable, was manifested in vocalizations against Blue Shield as an entity, but it is clear that it was not the objective and was not the effect of the dentists' actions to harm Blue Shield competitively.

5. Blue Shield certainly seeks to have its cake and eat it too. It initiated and encouraged an institutional response from the dentists to its "participating dentist" program from the

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7. See, also, *United States v. American Medical Association*, 110 F.2d 703 (D.C. Cir. 1940); 130 F.2d 233 (D.C. Cir. 1942).

dentists, and so long as everything was "coming up roses"[8] it had no concern that the dentists were acting in concert to become "participating" dentists. When the dentists, somewhat institutionally and somewhat in concert, in the face of an unyielding Blue Shield that by then enjoyed considerable success with its participating dentist program, acted to no longer "participate", it yelled foul and claimed an antitrust violation. We think it obvious that the very notion of participating dentist status and all of the elements of Blue Shield's program contemplates and virtually requires an institutional reaction from the dental profession. At the very least, Blue Shield may not fairly have it both ways; it may not initiate dealings with the dentists and dental associations collectively and then claim an antitrust violation on the basis of the dentists' collective response.

6. The "participating dentist" system constitutes a major revision of relationships and practices in a market which Blue Shield characterizes as being, as of the 1960s and early 1970s, "still a cottage industry . . . one of the last bastions of rugged individualism." Blue Shield brief, Doc. 972, p.12. The "participating dentist" system was not born of the natural interaction of free market forces or from the development of a product having a natural or inherent commercial worth; rather, it depended for its birth upon statutes of the Pennsylvania General Assembly and other actions of Pennsylvania government. Apart from the implications of these factors upon the merits of the dentists' *Noerr-Pennington*[9] political expression defenses here, the fact is that the emergence of the participating dentist system into the dentists' workplace did not constitute so much the entry of a new competitor or a new product into the market place, but rather the entry of a prospective new set of rules, policies and operating procedures. Dentists did not want to be second-guessed in their diagnoses and treatment of patients and they did not want to submit x-rays and study models to be scrutinized

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8. Blue Shield's brief, Doc. 972, p.16.

9. *Eastern Railroads' Railroad Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965).

by insurance carriers. Blue Shield and other insurance companies viewed themselves as more than mere financial intermediaries, but also as representing subscribers as bargainers of quality and cost of treatment. Thus, this observation is warranted: Blue Shield, which is unwilling in this antitrust case to commit itself to a position which incorporates the traditional building blocks of antitrust analysis (a relevant market and a particular product), and also seeks to protect by this litigation not so much a product as a system which incorporates features of policy and law as much as the features of a product, is seeking a result which would incapacitate the dentists from speaking out collectively and acting collectively with respect to this system.

If Blue Shield may enter upon the scene of an industry such as the practice of dentistry and may impose a wholly different and arguably quite artificial new set of economic relationships between dentists and patients, may initiate practices which (although they do not violate the antitrust laws) may tend to influence a dentist's fees and charging policies, there is no conceivable reason why the antitrust laws should prohibit the dentists from discussing such a development or from deciding collectively to remain, as it were, independent market entities. There is certainly no evidence that the dentists "conspired" to do more than that; *i.e.*, to maintain an industry of individual practitioners charging, on an individual dentist basis, what the market will bear. They did not by any stretch of the evidence conspire to fix prices; in truth, they viewed Blue Shield as the price fixer.

Having established our frame of reference by these foregoing observations, we turn to the question whether there are any facts presented by Blue Shield in connection with this Rule 56 motion which could, if proven, establish that a violation of the Sherman Act *per se* has occurred or that a violation has occurred by application of the rule of reason.

3. PER SE VIOLATION.

One of Blue Shield's arguments is that the dentists and associations violated the Sherman Act *per se* because their

conduct stabilized prices in Market I (or sought to). They explain this argument by asserting that the dentists' opposition to Blue Shield's "discount pricing" was and is a substantial factor in their boycott activity. Blue Shield asserts that "[t]he evidence also shows that collective opposition to discount pricing, by non-participation, reduced the risk that non-pars would lose Blue Shield subscriber patients to pars. By collective refusing to participate, dentists could balance bill *and* retain their patient volume." Blue Shield brief, Doc. 983, p.11. Simplified, and considered in view of the facts cited by Blue Shield, this argument says nothing more than that the dentists, by refusing to become or remain participating dentists, could bill their patients their ordinary fee. Since Blue Shield has not shown that for individual dentists acting unilaterally to bill their ordinary fee in the presumptively free market for dental services had any tendency to fix or stabilize prices, there is no conceivable basis in the facts presented for the Court to find that the dentists' activities amounted to price fixing.[10]

The cases cited by Blue Shield in support of its *per se* argument are not analogous to this case. In *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940), oil companies and individuals had been acting in concert to purchase cheap (distress) gasoline, to keep it off the market and thereby to raise and stabilize the market price for gasoline. Here, there is no proof of any purpose or effort to raise or to stabilize prices. The evidence shows the dentists to have been concerned about

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10. Blue Shield intimates that the dentists sought to retain certain advantags of Blue Shield's presence in the market without doing business with Blue Shield. This is misleading. Blue Shield's practice, the record indicates, is to pay benefits to the patient when the dentist is not a participating dentist. Thus, the dentist's relationship to his patient is largely unaffected by Blue Shield's presence in the background as a third-party payor. To the extent that patients, because of insurance coverage, purchase services they would otherwise forego, that is merely a neutral factor arising naturally from the existence of this sort of insurance and nothing the dentists are responsible for. Furthermore, even if Blue Shield did pay non-participating dentists directly, thereby benefiting them by virtue of certainty of payment, that too would merely be a neutral factor arising from the existence of insurance coverage in the market.

losing control as individual economic entities over their pricing practices, and that is not at all the same thing. Blue Shield's argument is premised upon the supposition that with sufficient participating dentists, dental prices would be lower. The Court has, however, already concluded that Blue Shield's programs do not have any inherent effect upon the pricing of dental services, *Pa. Dental Ass'n. v. Med. Serv. Ass'n. of Pa.*, 574 F.Supp. at 467-468, a conclusion which Blue Shield in that context advocated. We have been presented with no sufficient basis here to alter that conclusion.

In *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980), the Court considered the antitrust implications of beer wholesalers agreeing to end granting credit to beer retailers, and concluded that such an agreement would violate the Sherman Act. The Court found this to be a horizontal agreement to fix prices. That case does not support Blue Shield's position here, because there is no proof or basis for inference that the dentists' decision not to be participating dentists tended to fix prices or to standardize pricing practices. Again, on the contrary, we have concluded already that the participating dentist/UCR factor is a neutral factor insofar as pricing is concerned, and the evidence here does not disturb that conclusion.

In *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), a group of doctors agreed together upon maximum prices to charge for certain services. As we said earlier, in reference to Blue Shield's participating doctor plan, "[h]ere there is no setting of a maximum fee, minimum fee or any fee at all." 574 F.Supp. at 465. We will not hear Blue Shield now to claim that the dentists acted in opposition to Blue Shield's discount pricing.

Blue Shield cites *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531 (1978) in support of its companion contention of a *per se* violation based upon an unlawful group boycott. In *St. Paul Fire*, a group of physicians claimed that a group of insurance companies were boycotting them to coerce them to submit to new coverage ground rules. The issue there was whether the alleged boycott fell within the boycott exception to the general rule of antitrust immunity for the business of

insurance under the McComan-Ferguson Act. Blue Shield cites the case for the proposition that a boycott is "a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target." 438 U.S. at 541. We can not conclude that the dentists boycotted Blue Shield. The evidence will not reasonably support such an inference. The dentists discussed and to some extent resolved not to be participating dentists, which happened to be a program which Blue Shield was trying to encorage. The dentists did not refuse to treat Blue Shield patients. They did not focus in their resolutions upon harming or boycotting Blue Shield as an entity, even though some individual speakers may have done so on a few occasions. They decided somewhat collectively that they did not want to become involved in a new and different system for the delivery of dental services, a system for which Blue Shield happened to be the principal sponsor. The dentists did not have a dispute with Blue Shield, and Blue Shield was not the dentists' target. The dentists had a dispute with the notion of third-party control over dentists' otherwise independent decision-making and the target of their dispute was the participating dentist system. That Blue Shield had a stake in that dispute does not make it a target of a boycott.

Even assuming *arguendo* that the evidence can be construed to support the inference that the dentists boycotted Blue Shield, there is not here a *per se* violation of the Sherman Act. " '[B]oycotts are not a unitary phenomenon.' P. Areeda, *Antitrust Analysis*, 381 (2d ed. 1974)." *St. Paul Fire*, 438 U.S. at 531. "[O]ne might even hold that any agreement affecting competitive behavior is necessarily an agreement that the collaborators will not buy or sell on any other terms; [footnote omitted] and there is no sharp logical distinction between refusing to sell at all and refusing to sell on condition." P. Areeda, *Antitrust Analysis*, 495-496 (3d ed. 1981). We have already concluded that Blue Shield's practices do not constitute an unlawful boycott of non-participating dentists. 574 F.Supp. at 468. Yet it is obvious that Blue Shield does business with the non-participating dentists on much different terms than it does with participating dentists. We must recognize that Blue Shield did not enter the

market in which it sells its participating dentist status to dentists, or the market in which it buys dental services from dentists, by negotiating with individual dentists. It sought to deal with the dentists as a group. If the dentists at that juncture had said as a group to Blue Shield that they (the dentists) would not agree to Blue Shield's terms, there would be no conceivable basis for Blue Shield to claim an antitrust violation. Under Blue Shield's own statement of the facts, what happened is that this process of negotiation persisted over a period of years until some of the dentists came to decide, more or less collectively, that they were not going to buy the package of which Blue Shield was the principal seller. Since Blue Shield in its own interests sought to and did deal with the dentists collectively, we do not believe that we now may find that collective action by the dentists constitutes an illegal *per se* group boycott. None of the cases cited by Blue Shield at pages 10-13 of its brief, Doc. 983, is inconsistent with this conclusion.

In *Indiana Federation of Dentists v. FTC*, 745 F.2d 1124 (7th Cir. 1984), *cert. granted*, No. 84-1809 (Oct. 14, 1985), the Court held that if there is concerted conduct by a group of competitors banding together to protect themselves from non-group competitors, there is an illegal *per se* boycott. If not, the rule of reason is applicable. Here, Blue Shield is not a competitor of the dentists in Market I or any other market. We think that the rule of reason is clearly applicable.

4. RULE OF REASON.

We turn to our examination of the dentists' conduct under the rule of reason. The test is whether, on balance, the challenged agreement is one that promotes competition or one that suppresses competition. *National Society of Professional Engineers v. United States*, 435 U.S. 679, 688. As already stated, we find there not to have been a boycott by the dentists of Blue Shield, but rather some discussion and agreement about not being participating dentists; *i.e.*, not agreeing to third-party payment, to treatment review, to audits, and so on. Likewise, we find there to have been no fixing of prices. However,

assuming *arguendo* the existence of a colorable antitrust violation, we now consider whether the conduct of the dentists, as established by Blue Shield's evidence, was anticompetitive.

Blue Shield asserts that the evidence is overwhelming that the dentists' primary motivation in urging non-participation was economic. We do not find this to be true. The evidence establishes very clearly that the dentists objected to the non-economic requirements of participating dentist status and to the prospect of being answerable to a third-party entity as to the standard and nature of the services they were providing to their patients. They objected to having a third party review their treatment of a patient. They objected to submitting x-rays and treatment plans to a third party.

As we concluded, above, this case is not like the *Michigan State Medical Society* case upon which Blue Shield relies. Here, there was no effort by the dentists to influence reimbursement rates. This case, on the other hand, is more closely analogous to *Indiana Federation*, *supra*, where the dentists had acted collectively with respect to particular conditions which third party group dental health insurers sought to impose; *i.e.*, submission of x-ray forms to the insurer. The Court in that case concluded, first, that because there was no evidence that the dentists' practices were directed against competitors of the dentists (*i.e.*, other dentists), there was no *per se* antitrust violation and the rule of reason was applicable. The court then applied the rule of reason and concluded that no antitrust violation had occurred, because there was no anticompetitive effect upon any relevant market. In applying the rule of reason, the court noted and relied upon the fact that the dentists were continuing to do business with the insurers; *i.e.*, they had not refused treatment of insured patients. The dentists merely had refused to comply with all of the conditions set forth by the insurers. Even though the insurers advanced these conditions as cost containment measures, the Court concluded that the dentists acted properly in joining together and deciding upon standards of dental care; even when that resulted in a concerted refusal by the dentists to deal with the insurers upon certain terms and conditions.

Here, as in the *Indiana Federation* case, the dentists did not refuse to deal with the health care insurers generally or with Blue Shield specifically. There is no evidence that the dentists did not treat Blue Shield patients. The concerted opposition here to "participating dentist" status is not materially distinguishable from the concerted refusal in *Indiana Federation* to comply with certain of the insurance companies' requirements. Blue Shield seeks to distinguish *Indiana Federation* by observing that "[t]herein, the refusal to deal involved withholding x-rays, a basic component of patient care. Herein, the Dentists refused to contract with Blue Shield at discount prices" Blue Shield brief, Doc. 983, p.17. This distinction is based upon a view of the facts of this case which has no support in the record. We have already rejected the dentists' contention that Blue Shield's reimbursement mechanism sets prices, since each dentist is free to set his own price for dental services and to participate or not to participate with Blue Shield. 574 F.Supp. at 467-468. This conclusion, of course, does not foreclose the possibility that the dentists' motivation in not participating with Blue Shield was economic, but it does require the inference that there is no inherent tendency of the participating dentist system to discount dental prices.[11] However, there is no other evidence before us which reasonably supports the inference that the dentists' and associations' resolutions to not be participating dentists had an anticompetitive effect.

On the basis of the observations we have stated above, at pages 45-51, which we will not repeat here, we find the dentists' departicipation not to create any anticompetitive conditions in Market I. Stated very simply, we do not see the existence of a system of third-party payment for dental care to have any effect upon the pricing of dental services in Market I and, so long as

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11. The UCR reimbursement mechanism, as we observed, discounts *some* dentists' usual fees, in exchange for which the dentist realizes certainty of payment. 574 F.Supp. at 469. The fact that *some* dentists' fees are discounted does not reasonably support the inference that the dentists' objections to the participating dentist mechanism had the purpose or effect of stabilizing or fixing prices for dental services or that the dentists' unwillingness to participate had an anticompetitive effect.

dentists do not react differently to Blue Shield patients then they do to other patients and do charge the same fees to Blue Shield patients as are charged to other patients, competition in Market I is wholly unaffected by the dentists' communications and conduct with respect to the question of participating dentist status.

We believe that we must consider, however, the question framed in *Indiana Federation*, even though Blue Shield declines to frame the question in that manner: whether the dentists' communications and concerted conduct has an anticompetitive effect among dentists in their policy of dealing with health care insurers. 745 F.2d at 1141. This framing of the question, translated into terms of market definition, addresses Market II (see, page 43, *supra*), the market in which participating dentist status is bought and sold.[12]

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12. Another market might briefly be considered — the market in which various dental insurers sell various forms of prepaid dental insurance. Blue Shield can not reasonably claim any antitrust injury in that market as the result of the dentists' conduct. Blue Shield has 32 to 35% of all dental prepayment plans in this market. See, App. to dentists' brief in opposition to motion for summary judgment, Doc. 879, pages 52-53. The dentists, in support of their summary judgment motion, have presented very persuasive evidence that Blue Shield has not suffered antitrust injury in that market. While Blue Shield does not have a monopoly in that market, 574 F.Supp. at 472, it is beyond any question the dominant seller in that market.

Blue Shield's position that the dentists' departicipation has an anticompetitive effect in that market may be seen to be premised upon its contention that, but for the dentists' departicipation, it could sell for lower prices in that market and in that sense make that market more competitive. As we have seen, however, that contention is premised upon the unsupported speculation that Blue Shield's program "discounts" the cost of dental services. As we have said, we do not find the evidence to show this to be true and we found to the contrary in the earlier decision. If Blue Shield's objective is in fact to gain "control" of the dentists so as to discount the price of dental services, (1) we erred in our earlier decision, and (2) the dentists' concerted conduct, to the extent that it was motivated by economic factors, was pro-competitive because it sought merely to maintain a free market in Market I; that is, a market in which economic power is dispensed, competition is high, and a competitor stands to prosper upon his or her merits. Since the dentists are not in the insurance market in any sense, that market is not a relevant market for purposes of this case.

In Market II, unlike the equivalent market in *Indiana Federation*, there is here for all practical purposes only one seller, Blue Shield. This is significant because negotiations betwen the dentists and the insurers collectively, which in *Indiana Federation* was seen to be concerted action by the dentists to refuse to comply with certain of the insurers' conditions, here assumes the appearance of a boycott of Blue Shield as an entity because it is the principal seller of participating dentist status. Despite this appearance, we find this case to be materially indistinguishable from *Indiana Federation* because the concerns about which the dentists here were negotiating and which caused their concerted conduct were legitimate concerns relating to the quality of care and were not anticompetitive.

Blue Shield maintains here that the dentists were motivated by economic considerations and not by quality of care considerations. However, we find there to be no evidence to reasonably support the inferences which Blue Shield would have us draw. Blue Shield claims in a conclusory fashion that the dentists' motivations were economic, but acknowledges that the evidence shows that the dentists did not want to be second-guessed in their diagnosis and treatment of patients, did not want to submit diagnostic aids and study models, and simply did not want third parties to intrude into the traditional dentist-patient relationship.[13] The views and motivations on the dentists' part may or may not have been socially desirable. So long as the dentists' motivations were not anticompetitive in purpose

13. Blue Shield cites, as an example of the boycott against it, the PDA's refusal to print an advertisement in the PDA's publication by which Blue Shield would have sought to solicit additional participating dentists in central Pennsylvania. There is no doubt, of course, that PDA was and apparently remains opposed to the participating dentist concept. The rejection of Blue Shield's advertisement is but one of many manifestations of that opposition. The resolutions of the dentists who agreed that they would not participate is another. But the fact that many of the dentists and PDA opposed the concept of participation with Blue Shield and acted consistent with that philosophy in their affairs certainly does not of itself warrant the conclusion that their actions were anticompetitive. If that were so, protected speech and associational activities would be seriously jeopardized.

or in effect, these are matters outside the scope of the antitrust laws. The desirability or undesirability from a social perspective of the prospect of the defeat of the participating dentists system by dentists' non-participation is a matter which might be within the province of the Pennsylvania General Assembly to address; this Court may not address it if no antitrust violation has occurred.

We conclude that, by application of the rule of reason, there are no material questions of fact in dispute and the third-party defendants are entitled to judgment as a matter of law with respect to the dentists' and associations' rejection of Blue Shield participating dentist status. We add that, were we presented with facts demonstrating that the dentists had involved themselves in concerted action to negotiate with Blue Shield over such matters as fees and rates, or that the dentists or associations had taken or threatened any repercussions against dentists who were or sought to be participating dentists, or that the dentists who chose not to participate did not do so on the basis of their own independent judgment and free will but rather because of pressures brought to bear upon them by other dentists or the associations, we would reach a different conclusion.

5. BLUE SHIELD'S "SHAM ACTIVITIES" CONTENTIONS.

The other phase of acitvity by the dentists which Blue Shield claims to be in violation of the antitrust laws is the dentists' and associations' legislative and judicial efforts begun in 1977 and continuing to the present. Blue Shield claims that the purpose of these challenges, protests and legal actions was to coerce Blue Shield to change its business practices so as to reduce price competition among dentists and to preserve the private practice fee-for-service method of financing dental services. Blue Shield claims that these activities constituted "shams" to disguise anti-competitive conduct and therefore are not entitled to the general immunity attendant to persons' petitions to their Government under the *Noerr-Pennington*

doctrine[14]

Blue Shield, as a non-profit health service corporation and the promoter of the system of participating physicians and dentists involved in this case, is the embodiment of a legislatively enacted system of health care financing introduced into the affairs of a profession which was, in Blue Shield's phrase, "one of the last bastions of rugged individualism." Considering this background, it is not possible to view the approaches made by the dentists and their associations to the legislatures, the courts and the Commonwealth's administrative agencies as a "sham," something other than legitimate collective petitioning of the government. It is a more accurate view of the dentists' conduct, viewing all of the evidence relied upon by Blue Shield, to perceive of all of their conduct at issue in this case, from the very inception of the participating dentist system, as conduct protected under the *Noerr-Pennington* doctrine. Even though the first court case was not brought until 1977 and the dentists' departicipation began in 1974, the evidence makes it clear that the actions taken by the dentists in their negotiations with Blue Shield, including their departicipation, were the direct result of the legislation and administrative agency rulings authorizing and establishing Blue Shield's participating dentist system. Blue Shield may itself be seen to be an instrument or agent of Pennsylvania government for the purposes of this case; that is, because it enjoys a special status as a non-profit health service corporation and may engage in practices which its profit-making insurance company competitors may not, it is quite possible to view the dentists' and associations' interactions with Blue Shield as in essence the petitioning of the government.

Blue Shield is an instrumentality of the government in the sense that it is a legislatively created entity (with respect to its characteristics of relevance to this case) designed, authorized and empowered to execute Pennsylvania public policy. It is characteristic of this special status enjoyed by Blue Shield that its enabling legislation causes it to distinguish between under-income and over-income patients for purposes of the billing of

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14. See, footnote 9, *supra*.

patients by participating doctors and dentists, a provision that is not generally consistent with the activities of the natural forces of a free market. However, we do not reach the question whether the dentists' concerted conduct, apart from their legislative and judicial efforts, are subject to the protection of the *Noerr-Pennington* doctrine, inasmuch as we have already decided that those activities did not violate the Sherman Act.

Little discussion need be devoted to the question whether the dentists' court actions, legislative lobbying and administrative agency litigation, commencing in 1977, falls within the *Noerr-Pennington* exception to the antitrust laws. Blue Shield says it is sham activity, designed to force Blue Shield to change its practices. Blue Shield's assertion, however, is not supported by any facts or law. Blue Shield's argument is, in essence, that because the dentists were illegally boycotting the "participating dentist" program, operated by Blue Shield, any contemporaneous action in the various governmental bodies against Blue Shield was a sham. We conclude, however, that there was no illegal boycott. Moreover, there is no evidence in Blue Shield's facts to demonstrate that the dentists and associations were doing other than advocating the positions they had been advocating all along, many of which are involved in this case. Blue Shield's assertion that the dentists were involved in a sham is unsupported.

III. CONCLUSION

". . . [C]ourts should not permit factfinders to infer conspiracies when such inferences are implausible, because the effect of such practices is often to deter pro-competitive conduct." *Monsanto*, 465 U.S., at 762-764; *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984); *Matsushita Elec. Ind. Co. v. Zenith Radio*, ____ U.S. ____, Slip Op. at p.18 (March 26, 1986).

This proposition is no less true as applied to the inference of an unlawful motive from circumstances not reasonably suggesting any such unlawful motive. By all appearances, the dentists' motive was pro-competitive. Assuming that Blue Shield proves

all of the facts it has presented for purposes of summary judgment, we have no doubt that this is what we would find. The dentists did not seek to raise, lower or stabilize prices, but to preserve a market in which excellence was rewarded and inferior service penalized. We cannot reasonably deny summary judgment and require a trial when the inferences that Blue Shield seeks to have us draw are not reasonable. As in *Matsushita*, there is little reason to be concerned that by granting summary judgment, illegal conspiracies will be encouraged. There is no evidence or indication here, for example, that any significant number of dentists will be influenced to act in concert not to participate with Blue Shield, even though they perceive it to be in their best interest to do so, merely because other dentists or the dental associations are advocating that they not participate. There is no indication that the PDA or any of the other associations wield such power or potential power over dentists that a dentist could be penalized or harmed in any manner for participating with Blue Shield. That is not the theory of Blue Shield's case here, in any event.

The proposition that the learned professions are subject to the antitrust laws does not advance Blue Shield's cause nearly so far as Blue Shield would have it. It means, of course, that the dentists may not fix prices. Nor may they concertedly refuse to deal with other commercial entities for anticompetitive purposes. It does not mean that they lose the prerogative to discuss and agree upon issues generally affecting their professional status and practices.

We must consider the possible effects of a ruling that the dentists' agreement not to participate does not violate the antitrust laws. Will the participating dentists system be destroyed? Will dentists choose to departicipate *en masse*? We think not, but will assume otherwise, that this will happen. We note, again, that any evidence of coercion by dentists upon other dentists to departicipate would support an antitrust violation, as would evidence of efforts by the dentists to fix or stabilize prices in the dental marketplace. Therefore, we will assume that the dentists' *en masse* departicipation will be the result of their collective assessment that their practice should not be subjected

to a set of conditions involving a third party in the treatment relationship between dentist and patient. The result is that, absent some action by the Commonwealth of Pennsylvania government, or some modification by Blue Shield of some of the components of its participating dentist program to make it less objectionable to the dentists, Blue Shield will be relegated to providing a form of dental insurance contract which involves only two parties, Blue Shield and the insured individual or group; *i.e.*, a simple reimbursement or partial reimbursement for dental costs to the dental patient. We may find that result regretable, but we do not find it to be anticompetitive. We see no reason, in the evidence or in logic, why this result should affect the price of dental services. Only if we were to assume for some reason that the market for dental services is not a free market could we conclude that the failure of the participating dentist system to work as Blue Shield hoped it would work is the result of anticompetitive forces or is anticompetitive in effect. Blue Shield has not asked us to make such an assumption in this case, nor is there evidence in this case to support such an assumption. On the contrary, Blue Shield's description of a market characterized by rugged individualism is perfectly consistent with all of the evidence in this case — the non-participating dentists' consistent theme and objective has been to remain independent entities in every possible respect. The dentists did not act in concert to eliminate the economic advantages of superior ability, efficiency and products or to ameliorate the economic disadvantages of an inferior dental practice; quite the contrary, they acted to preserve these. Unless we radically misunderstand the concept of free trade and the objectives of the antitrust law, this is not the sort of activity that these laws seek to prevent.

We recognize that when motivation and intent are in issue, summary judgment is not very likely to be appropriate. It is important here to analyze this case very precisely in relationship to that principle. When we do, we find that there is really not a genuine material factual dispute relating to motivation and intent. The picture is clear, and it is this: Some individual dentists did form and express a view of their position vis-a-vis

Blue Shield and the participating dentist concept that incorporated the notion that Blue Shield should be driven out of business through dentists' departicipation. These individual dentists are not defendants in this case. These individual dentists' statements and conduct are not, in view of all of the evidence, either representative or indicative of the motivation and intent of the dentists and associations generally. The motivation and intent of the dentists and associations generally was directed against the overall body of rules and practices associated with the participating dentists concept. It was the dentists' and associations' view, which was entirely reasonable and accurate, that if the dentists were to become participating dentists on a universal or nearly universal basis, dentists' independence and the traditional dentist-patient relationship would be largely sacrificed and dentists would come under the control of third-party insurers for purposes of a very broad range of the dentist's affairs including his treatment decisions and his billing practices. Thus, there is no genuine material factual dispute as to the question whether the dentists and associations were motivated by a desire to harm Blue Shield competitively. There is no material evidence of an effort on the dentists' part to harm Blue Shield as an entity in any market, and certainly not as a purchaser of dental services in Market I. The evidence upon which Blue Shield relies, upon a structured and precise review of it, reasonably supports no more than the inference that many of the dentists and their associations sought to defeat the success of a major systemic change in the practice of dentistry and in the delivery of dental services. This dispute between the dentists and the forces seeking to change the way that dental services are administered will no doubt give rise to many legal and policy issues in various forums for many years to come; however, in the context of the Sherman Act, this objective and these efforts on the part of the dentists may not reasonably be seen to be anticompetitive.

For these reasons, the third-party counterclaim defendants' motion for summary judgment will be granted. An appropriate Order will be issued.

William W Caldwell
United States District Judge

Dated: April 17, 1986.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

PENNSYLVANIA DENTAL ASSOCIATION, *et al.*, *Third-Party Plaintiffs*	:	CIVIL ACTION NO. 81-1187
v.	:	
MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, *et al.*, *Third-Party Defendants*	:	

ORDER

AND NOW, this 17th Day of April, 1986, IT IS HEREBY ORDERED that summary judgment is granted in favor of the third-party counterclaim defendants (the dentists and their associations) and against the third-party counterclaim plaintiff (Blue Shield).

The Clerk is directed to close this file.

William W. Caldwell
United States District Judge

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

PENNSYLVANIA DENTAL ASSOCIATION, *et al.*, *Third-Party Plaintiffs*	:	JUDGMENT IN A CIVIL CASE
v.	:	CASE NUMBER: CIVIL NO. 81-1187
MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, *et al.*, *Third-Party Defendants*	:	

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDER AND ADJUDGED that Summary Judgment be and hereby is entered in favor of the third-party counterclaim defendants, York County Dental Society, Fifth District Dental Society, Dennis W. King, D.D.S., Charles M. Ludwig, D.D.S., Theodore R. Paladino, D.D.S., Thomas L. Perkins, D.M.S., and Kay F. Thompson, D.D.S. and against the third-party counterclaim plaintiff, Medical Service Association of Pennsylvania, d/b/a Pennsylvania Blue Shield.

APRIL 17, 1986
Date

Donald R. Berry
Clerk

(By) Deputy Clerk

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 86-5338

PENNSYLVANIA DENTAL ASSOCIATION;
DELAWARE COUNTY DENTAL SOCIETY;
ERIE COUNTY DENTAL ASSOCIATION, INC.;
HARRISBURG AREA DENTAL SOCIETY;
LUZERNE COUNTY DENTAL SOCIETY;
MONTGOMERY-BUCKS DENTAL SOCIETY;
ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA;
SCRANTON DENTAL SOCIETY; and
YORK COUNTY DENTAL SOCIETY;

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA,
d/b/a PENNSYLVANIA BLUE SHIELD,

Appellant

v.

YORK COUNTY DENTAL SOCIETY,
FIFTH DISTRICT DENTAL SOCIETY,
DENNIS W. KING, D.D.S.
CHARLES M. LUDWIG, D.D.S.
THEODORE R. PALADINO, D.D.S.
THOMAS L. PERKINS, D.M.D.
and KAY F. THOMPSON, D.D.S.

3rd party Counterclaim Defts.

SUR PETITION FOR REHEARING

Present: GIBBONS, *Chief Judge*, SEITZ, WEIS, HIGGINBOTHAM, SLOVITER, BECKER, STAPLETON, MANSMANN and HUNTER, *Circuit Judges*

The petition for rehearing filed by appellees in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

By the Court,

_____

Chief Judge

Dated: April 23, 1987

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 84-5004

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA: SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

(Third Party Plaintiffs)

vs.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY,

(Third Party Defendants)

COUNTERCLAIM DEFENDANTS
York County Dental Society, Fifth District Dental Society, Dennis W. King, D.D.S.; Charles M. Ludwig, D.D.S.; Theodore R. Paladino, D.D.S.; Thomas L. Perkins, D.M.D.; and Kay F. Thompson, D.D.S. Pennsylvania Dental Association; Delaware Valley Dental Society; Erie County Dental Association, Inc.; Harrisburg Area Dental Society; Luzerne County Dental Society; Montgomery-Bucks Dental Society; Odontological Society of Western Pennsylvania; Scranton District Dental Society; Charles M. Ludwig, D.D.S.; Dennis W. King, D.D.S.; Theodore R. Paladino, D.D.S.; Thomas L. Perkins, D.M.D.

Appellants

Appeal from the United States
District Court for the
Middle District of
Pennsylvania — Scranton
(D.C. Civil No. 81-1187)

Argued
August 14, 1984
Before: ALDISERT, *Chief Judge*, WEIS,
Circuit Judge, and RE, *Judge*.*
(Filed October 1, 1984)

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* Honorable Edward D. Re, Chief Judge of the United States Court for International Trade, sitting by designation.

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OPINION OF THE COURT

ALDISERT, *Chief Judge*.

This appeal requires us to decide whether Blue Shield's prepaid dental service program in Pennsylvania violates the antitrust laws. Several Pennsylvania dental associations and individual dentists appeal from a summary judgment dismissing their antitrust and state law claims brought against the Medical Service Association of Pennsylvania, doing business as Pennsylvania Blue Shield.[1] Appellants argue that Blue Shield engaged in a price-fixing conspiracy and a group boycott in violation of §1 of the Sherman Act, 15 U.S.C. §1, attempted to monopolize and monopolized in violation of §2 of the Act, 15 U.S.C. §2, and that the district court abused its discretion in refusing to certify a subclass of cooperating dentists for treble damages purposes. We conclude that appellants' contentions are without merit, and therefore affirm the judgment of the district court.

I.

This lawsuit is a vestige of an ill-fated action brought by the Commonwealth of Pennsylvania against nine dental associations in the state charging that they ran afoul of antitrust laws and Pennsylvania law by discouraging dentists from participating in

1. We have jurisdiction under 28 U.S.C. §1291 because the district court entered a final judgment certified pursuant to Rule 54(b). F. R. Civ. P. That rule provides in relevant part:

> (b) Judgment Upon Multiple Claims or Involving Multiple Parties. When more than one claim for relief is presented in an action, whether as a claim, counterclaim, cross-claim, or third-party claim, or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment.

the Blue Shield program. Essentially, the complaint accused the dentists of restraining trade under §1 of the Sherman Act. The associations, however, countered with an antitrust action of their own, filing a third-party complaint against Blue Shield charging violations of §§1 and 2 of the Sherman Act, alleging that the determination of fees paid dentists by Blue Shield constitutes price fixing and a boycott, and further, that with its market power and through anticompetitive acts, Blue Shield is attempting to or is monopolizing certain relevant Pennsylvania markets and submarkets. They also asserted state law claims and requested treble damages, injunctive relief and punitive damages.

After extensive discovery, the state dismissed the Commonwealth's complaint against the associations over the objections of Blue Shield, leaving only the third-party action to survive. Blue Shield then counterclaimed against the original defendants, an additional dental society and five individual dentists, asserting a violation of §1 of Sherman and alleging a conspiracy to boycott Blue Shield's dental programs by causing their members to terminate their participating agreements with Blue Shield, to fix charges for services paid under Blue Shield's dental program, to impede Blue Shield's cost containment efforts and to discourage dental insurance purchasers from enrollment or continued enrollment in Blue Shield's dental programs. This counterclaim also asserted causes of action under state law including tortious interference with contractual relations, civil conspiracy and trade libel. But there was more to come. Four of the five individual dentists then filed a class action in the form of a counterclaim against Blue Shield, and, like the dental associations, alleged Sherman §§1 and 2 violations. Remaining are the litigants presently before us. Arrayed on one side are the Pennsylvania Dental Association, Delaware County Dental Society, Erie County Dental Association, Harrisburg Area Dental Society, Luzerne County Dental Society, Montgomery-Bucks Dental Society, Odontological Society of Western Pennsylvania, Scranton Dental Society, York County Dental Society, Dennis W. King, Charles M. Ludwig, Theodore R. Paladino, and Thomas L. Perkins. On the other side are Blue Shield and Donald S. Mayes, one of its officers, being sued in his

own right.[2]

We consider in this appeal, in its Rule 54(b) context, only the summary judgment entered in favor of Blue Shield in the third-party complaint and in the class action counterclaim asserted against it. Not before us, and presumably still very much alive in the district court, is Blue Shield's counterclaim against the appellants.

II.

The controversy concerns Blue Shield's prepaid dental service program in Pennsylvania. Under that program, Blue Shield purchases dental services from providers in bulk and sells them to group subscribers only. It does this through a series of provider and subscriber contracts, covered by what is known as its Penn Dental I program. Blue Shield also markets an indemnity dental program known as Penn Dental V. Dentists who choose to participate with Blue Shield enter into provider contracts that obligate them to accept a set fee from Blue Shield as their sole payment for providing services to Blue Shield subscribers. The reimbursement system establishing that set fee is based on the "usual, customary, and reasonable" (UCR) fees charged by Pennsylvania dentists for specific dental procedures.

Blue Shield enters into subscriber contracts with patients that provide that if covered services are obtained from a participating dentist, the subscriber will not be required to pay any additional or out-of-pocket amounts. Payment is made directly to the participating dentists by Blue Shield because participating dentists have agreed to accept the UCR fee for their services.

The subscriber contracts also cover dental services performed by dentists who do not participate in the Blue Shield program (non-participating dentists). But Blue Shield subscribers are not assured of paid-in-full service benefits if they obtain services from non-participating dentists. Blue Shield will pay only the predetermined UCR fee. Moreover, payment for

2. For the purpose of this opinion we will refer to both appellees as Blue Shield.

non-participating dental services is made directly to the subscriber and not to the dentist.

Thus, generally speaking, the essential difference between participating dentists and non-participating dentists in the Blue Shield program is twofold; where the dentist participates, he is paid directly by Blue Shield and he agrees to accept the UCR fee as payment in full for services rendered a subscriber. Dentists who do not participate do not agree to be bound by the UCR fee; subscribers are personally responsible for any amount charged by such dentists in excess of this fee; moreover, the Blue Shield reimbursement is paid directly to the subscriber and not to the dentist.[3]

The thrust of appellants' price fixing complaint focuses primarily on Blue Shield's method of determining the UCR fee. It therefore becomes necessary to discuss first the relationship of participating dentists to the Blue Shield structure and second the mechanics of determining the UCR charge.

A.

Blue Shield's by-laws provide that its business shall be managed by a board of directors and that lay persons shall constitute one-half of the board. That provision is in accordance with 40 Pa. Cons. Stat. Ann. § 6328(b)(1), which requires that at least 50% of Blue Shield's board consist of lay persons. The board consists of 32 members, 16 lay persons and 16 doctors. Only two members of the board are dentists.

Standing committees of various composition exist within the Blue Shield corporate structure to consider matters referred to them by the board or management of Blue Shield. Committee members are appointed by the chairman of the board. Two of these committees, of which dentists constitute a majority, command our interest.

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3. Other differences between participating and non-participating dentists include Blue Shield's refusal to grant non-participating dentists "excepted" dentist status, thereby requiring them to get pre-approval for new, expensive treatment, and its refusal to allow non-participating dentists to use the simpler claim forms used by participating dentists.

The Dental Policy Committee (now known as the Dental Affairs Committee) considers matters referred to it by the board or by management and forwards its recommendations to the board for approval. The specific functions and responsibilities of the policy committee include; (1) examination and determination of the validity of new dental procedures; (2) review and reappraisal of current payment policies; (3) development of guidelines for maintaining a UCR mechanism; (4) development of guidelines for establishing fee schedule allowances; (5) provision of guidance to enhance provider participation; (6) review and reappraisal of the *Regulations for Participating Doctors;* and (7) review and appraisal of new health delivery systems. Many of these matters may reasonably be considered only by dental practitioners. Although the Blue Shield staff selects the majority of items on the committee's agenda, items are placed on it pursuant to requests from non-participating dentists as well as the public.

The Dental Review Committee is responsible for reviewing and making recommendations on matters affecting the status of dentists who participate in the Blue Shield program. These matters relate to conduct incompatible with participating dentist status, such as failing to verify charges with Blue Shield. The committee also considers disputes between Blue Shield and dentists involving questions of professional ethics. The composition of the review committee is established pursuant to Blue Shield's by-laws in accordance with state statute, 40 Pa. Cons. Stat. Ann. § 6324(c).

B.

The parties do not dispute the mechanics of determining UCR charges. Under this system, when Blue Shield receives a bill with a dentist's fee, or charge, for a covered service, Blue Shield does not automatically allow payment of the full charge. Rather, the "allowance" may be different from the dentist's fee because of the operation of the three separate "screens" or artificial calculations — usual, customary, and reasonable.

The "usual charge" screen looks at the fees that an individual dentist most frequently charges patients for the procedure

performed (*e.g.*, a particular type of filling or crown) during a specific time period in the past (base period). These usual charges (sometimes referred to as a dentist's profile) range from low to high, and the "usual charge" screen will set the maximum allowance at a specific percentile of the past charges. Since 1979, Blue Shield's usual charge screen has been the 75th percentile.

The "customary charge" for a particular procedure is measured as a function of all the "usual charges" of all dentists in Pennsylvania in the same speciality classification (of which there are five) during a designated base period. Since at least 1975, Blue Shield limits its allowance for any particular procedure to the 90th percentile of those charges. In recent years it has used the "usual charges" of the preceding calendar year as the base period.

The reasonable charge screen applies only in special circumstances, *e.g.*, when a dental procedure involves unique problems that require more time by the dentist. When special circumstances exist, Blue Shield might pay a larger percentage of the fee than would normally be allowed under the usual and customary charge screens. The extra allowance is determined by referring the claim to one of Blue Shield's dental advisors — a practicing dentist who works part-time for Blue Shield. The reasonable charge screen apparently is relevant to only a small percentage of claims; the usual and customary charge criteria come into play much more often.

III.

It bears emphasis that the state initiated this action in 1981 by filing a complaint against the dental associations charging the associations with violating the antitrust laws by encouraging dentists to terminate their Blue Shield provider contracts. With the dispute of those particular parties behind us, and limited to a Rule 54(b) determination, we must now consider the reverse argument: whether Blue Shield has violated the federal antitrust laws.

Appellants first argue that Blue Shield engaged in a price-fixing conspiracy and an illegal group boycott in violation of § 1

of the Sherman Act. They then argue that Blue Shield monopolized and attempted to monopolize certain Pennsylvania dental services markets in violation of § 2 of the Sherman Act. Finally, four of the individual dentist appellants argue that the district court erred in refusing to certify a subclass of cooperating dentists for treble damages purposes.

Our standard of review follows settled precepts. Because the district court rejected appellants' Sherman §§ 1 and 2 arguments on summary judgment, we must affirm if we determine that there are no disputed issues of material fact and that Blue Shield is entitled to judgment as a matter of law. *Coastal States Gas Corp. v. Department of Energy*, 644 F.2d 969, 978-79 (3d Cir. 1981). Although summary judgment should be used sparingly in complex antitrust litigation, *Poller v. Columbia Broadcasting System*, 368 U.S. 464, 473 (1962), its use is not forbidden, *see Harold Friedman, Inc. v. Kroger Co.*, 581 F.2d 1068, 1071 (3d Cir. 1978). As to the district court's refusal to certify the subclass, we must affirm in the absence of an abuse of discretion. *Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239, 245 (3d Cir.), *cert. denied*, 421 U.S. 1011 (1975).

IV.

As can be immediately perceived, appellants' arguments do not follow a narrow compass. They range far and wide through a thicket of antitrust law. We are required to discuss in one opinion such diverse concepts as horizontal and vertical price-fixing agreements, group boycotts, attempts to monopolize and actual monopoly in alternative markets, and, as a separate issue, the question of certifying a class action. All of this demands a discussion much more extensive and prolonged than that which we prefer to set forth in a typical decision of this court.

We turn first to appellants' restraint of trade arguments. Section 1 of the Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States" 15 U.S.C. § 1. To establish a violation of § 1, plaintiff must show evidence of concerted action that unreasonably restrains trade. *Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1 (1911). If an agreement is

manifestly anticompetitive, it is conclusively presumed to be unreasonable and therefore deemed illegal *per se*. *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49-50 (1977); *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 5 (1958). Otherwise, the agreement must be analyzed under the rule of reason, which requires the factfinder to determine whether, under all the circumstances of the case, the restrictive practice imposes an unreasonable restraint on competition. *Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918). Essential to a finding of a § 1 violation is concerted action; unilateral action is not proscribed. *Monsanto Co. v. Spray-Rite Service Corp.*, ____ U.S. ____ (52 U.S.L.W. 4341, 4343, 1984); *Malley-Duff & Associates, Inc. v. Crown Life Insurance Co.*, 734 F.2d 133, 141 (3d Cir. 1984). Here, appellants argue that Blue Shield's conduct can be condemned as either illegal price-fixing or an illegal boycott, both *per se* violations of Sherman § 1.[4] We proceed to consider first appellants' price-fixing allegations and then their boycott claim.

V.

To determine whether Blue Shield has engaged in illegal price-fixing, we must decide whether Blue Shield may, consistent with the Sherman Act, establish a "usual, customary, and reasonable" reimbursement system and enter into bilateral provider agreements with individual dentists that obligate them to accept that reimbursement as payment in full for their services. Appellants contend that such an arrangement is illegal *per se* because Blue Shield did not act unilaterally in setting the reimbursement formula. They maintain that those dentists

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4. Appellants appear to have abandoned the rule of reason in this appeal, contending instead that "The Rule of Reason Does Not Apply Here," "The District Court was wrong in applying the rule of reason at all," and "use of the rule of reason was error as a matter of law." Brief for appellants at 35, 40. Notwithstanding this express disclaimer of application of the rule of reason, appellants made further reference to the rule in their brief, arguing that the district court's rule of reason analysis, even if appropriate, was incorrect. *Id.* at 35-36, 40. Appellants discussion was so cursory, however, that this court is led to believe that appellants are not pursuing the rule or reason on appeal.

participating in the Blue Shield program and competing with them conspired and acted through Blue Shield, as their agent, to establish and implement the UCR system. This argument appears to be based on a theory of structural horizontal conspiracy with a vertical link. It is dependent upon proof that participating dentists, through their majority membership on the two Blue Shield committees, actually controlled the establishment of the UCR system implemented by Blue Shield.

Appellants also contend that the arrangement with Blue Shield is illegal *per se* because the dentists did not decide independently to participate. They argue that Blue Shield economically coerced them to enter into the provider agreements and accept the UCR reimbursement formula contained therein. This argument advances a theory of vertical restraint. It is dependent upon proof that the provider agreements themselves were the product of coercion or collaboration rather than merely bilateral contracts for the sale and purchase of services at a price unilaterially fixed by the purchaser and individually agreed to by the seller. Under either theory — structural horizontal conspiracy or vertical restraint — appellants argue that the UCR reimbursement formula, the subject of concerted action, is the type of pricing restraint condemned by the *per se* rule.

The Supreme Court has held that any combination formed for the purpose and with the effect of raising, depressing, fixing, pegging or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se* under § 1 of the Sherman Act. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). Pursuant to this rule, it has condemned horizontal agreements among competitors to fix prices, *see id.*; *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980)(holding horizontal agreement among competitors to fix credit terms *per se* violation of § 1), as well as vertical resale price maintenance agreements, *see Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211 (1951)(holding distillers' agreement on maximum resale price of liquor sold by distributors *per se* violation of § 1) and *Albrecht v. Herald Co.*, 390 U.S. 145 (1968)(holding publisher's establishment of maximum resale price of newspapers sold by carriers

per se violation of § 1). These decisions make clear that the *per se* rule applies to "an agreement to fix the price to be charged in transactions with third parties, not between the contracting parties themselves." *See Sitkin Smelting & Refining Co. v. FMC Corp.*, 575 F.2d 440, 446 (3d Cir.), *cert. denied*, 439 U.S. 866 (1978).

If we characterize the provider agreements at issue here as "merely arrangements for the purchase of goods and services by Blue Shield," *Group Health & Life Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979), Blue Shield can be viewed as a purchaser of dental services. As such, its establishment of the price it will pay the participating dentists with whom it contracts, as distinguished from the price it will charge third parties, is not price-fixing within the scope of the *per se* prohibition of § 1. *See Sitkin*, 575 F.2d at 446. Yet because Blue Shield is a purchaser that only partially reimburses the participating dentists for each sale of services, the participating dentists, in effect, are making one sale to a two-sided buyer composed of the insurer and the subscriber. It is probably more accurate, therefore, to characterize Blue Shield as an indemnitor or third-party payor — the ultimate payor — rather than as a purchaser. Thus, we must proceed to analyze Blue Shield's conduct under the traditional notions of horizontal and vertical price-fixing.

A.

Most recently, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Supreme Court found a medical insurance plan to be illegal *per se* as a horizontal price-fixing conspiracy. Defendants there were non-profit foundations composed of medical doctors. The member physicians, by majority vote, set maximum fees limiting the amount that they could recover as payment for services performed for patients insured under the approved insurance plans. These plans obtained foundation approval by agreeing to pay the doctors' charges up to a scheduled amount in return for the physicians' agreement to accept that amount as payment in full. The Court held that an agreement among competing physicians

setting the maximum fees that may be claimed in full payment for health services provided to policyholders of specified insurance plans constitutes a *per se* violation of § 1. *Id.* at 335-36.

With respect to the case at bar and appellants' theory of horizontal conspiracy, however, there is no overt agreement among competing health care providers to establish or to fix prices as was the situation in *Maricopa*. That distinction, however, does not necessarily preclude a finding of a horizontal price-fixing agreement. To the extent that Blue Shield's establishment of the UCR reimbursement system might disguise or embody an agreement among competing providers, its actions would come within the purview of § 1. *See United States v. Paramount Pictures, Inc.*, 334 U.S. 131 (1948); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980); *see also Maricopa*, 457 U.S. at 352 n.26 (reserving question of whether insurer, who may be under control of providers, can lawfully fix the fee schedule and enter into bilateral contracts with individual providers).

Several recent cases have dealt with a concept that seeks to prove a horizontal agreement by a theory of structural conspiracy. In *Virginia Academy*, the Fourth Circuit found that Blue Shield plans were combinations of physicians operating under the direction and control of their physician members, 624 F.2d at 481. In that case, the plans' by-laws required that a majority of the board of directors be physicians, and there was evidence in Blue Shield documents and statements tending to show physician control. In *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia*, 498 F. Supp. 63, 66 (E.D. Va. 1980), the court applied the "walking conspiracy" theory of *Virginia Academy* and found no provider control of Blue Cross, noting that Blue Cross's enabling statute required that a majority of a plan's board of directors be subscribers; that the board in fact had a subscriber majority, and that there was no direct evidence of member control of Blue Cross.[5]

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5. Appellants argue that the decisions in *Glen Eden Hospital, Inc. v. Blue Cross & Blue Shield of Michigan*, ____ F.2d ____ (6th Cir. No. 83-1165, July 16, 1984), and *Ratino v. Medical Services of the District of Columbia (Blue Shield)*, 718 F.2d 1260 (4th Cir. 1983), which applied the "walking

We reject appellants' theory of structural horizontal conspiracy because the uncontroverted facts furnish no support for it. There is no genuine issue of material fact concerning Blue Shield's corporate and operational structure. The board of directors has the ultimate responsibility for Blue Shield's business decisions and only two members of its 32-member board are dentists. Health care providers do not constitute a majority on the board. The district court found that "[o]nly one-sixteenth of the persons responsible for making the decisions which [appellants] claim[] to be potentially and in fact anti-competitive are themselves competitors in the relevant market." Mem. op. at 15, *reprinted in* app. at 3386.

Appellants' structural conspiracy argument seems to ignore the construction of Blue Shield's board and focuses instead on the functions and composition of the review and policy committees. These facts are essentially not disputed. Admittedly, dentists constitute a majority on each of these committees. But majority membership on a committee, without more, does not make out a prima facie case of structural horizontal conspiracy. The power and the authority of that committee must be analyzed. As did the district court, we conclude that these committees were advisory only, that they were constituted and utilized as a resource to the board, that they participated in no

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conspiracy" theory of *Virginia Academy*, militate in favor of finding provider control in the case at bar. We find both cases distinguishable. The Sixth Circuit in *Glen Eden* reversed the district court's conclusion that there was no provider control of Blue Cross. In *Glen Eden*, however, appellant-hospital was allowed only severely limited discovery and its requests for information directly related to the theory that participating hospitals either controlled or greatly influenced the reimbursement policy of Blue Cross were denied. For this reason, the *Glen Eden* court concluded that the grant of summary judgment was premature. In the case before us, unlike *Glen Eden*, the parties have completed extensive discovery.

In *Ratino*, the Fourth Circuit reversed a summary judgment in favor of Blue Shield. There, the district court had concluded that the UCR plan fell within the McCarran-Ferguson Act's "business of insurance" exemption, *see* 15 U.S.C. §§ 1011-1015, thereby shielding the plan from antitrust scrutiny. Holding the McCarran-Ferguson Act inapplicable, the *Ratino* court remanded the case for fact findings and a determination as to whether Blue Shield's challenged practices constitute a price-fixing conspiracy or an illegal boycott.

activities anathematic to antitrust precepts, and rendered advice only when particularly solicited by the board. Appellants appear to concede that the policy committee does not approve policies for the board, but merely makes recommendations to it. We are not impressed by appellants' specific contentions in this respect, including its emphasis on the statement of one Blue Shield official that he could not remember any occasion when the policy committee's recommendation was not accepted by the board. Appellants argue that the committee developed, voted on, and specifically approved Blue Shield's system for calculating the customary charge screen, as well as the switch to the 10% differential (or 90% performance level) and the use of statewide classes for calculating the customary charge. But it is not controverted that the use of statewide charge classes and the goal of seeking to allow at least 90% of aggregate charges were concepts developed and urged by management. Approval of these concepts by the policy committee was simply an approval of a management decision. Nor do appellants deny that the policy committee simply followed the recommendation of another committee in suggesting the allowance of the percentage of aggregate charges reported to the dental program. Action taken to find a market price so that a purchaser-insurer does not overpay does not constitute price-fixing.

Nor do we accept the notion that the review committee participated in price-fixing when it refused to update profiles of dentists who refused to verify their usual charges pursuant to Blue Shield procedures that called for "in-office reviews" of charges. The following factors strongly militate against appellants' argument: Blue Shield's requirement that dentists certify that their fees submitted to Blue Shield have not been inflated because of insurance coverage is consistent with the ethical rules of the dental profession. Blue Shield's in-office review experience showed that about one-half of the dentists who agreed to verify their usual charges had charged inflated fees to Blue Shield and that about one-third of the dentists contacted refused to verify their usual charges, the state health department has

approved the concept of Blue Shield conducting in-office reviews to verify dentists' usual charges, and profile updates were not withheld until the board of directors authorized such action.

Distilled to its essence, the question comes to this. Blue Cross, as a purchaser of or ultimate payor for dental services, sought advice on the design and operation of its dental program from committees composed primarily of practicing dentists. To give advice when asked by the decisionmaker is not equivalent to being the decisionmaker itself. We see no dispute of material fact on this issue and we conclude that there was no support for appellants' structural horizontal conspiracy argument.[6]

B.

Once appellants' horizontal theory of concerted action is eliminated, they are left with trying to prove that the provider agreements themselves evidence an unlawful vertical restraint. The Supreme Court does not condemned vertical price-fixing outside of the resale price maintenance context. *See Albrecht v. Herald Co.*, 390 U.S. 145, 151 (1968)(*resale* price fixing is a *per se* violation); *Kiefer-Stewart Co. v. Joseph Seagram & Sons*, 340 U.S. 211 (1951). As the Blue Shield provider agreements here differ greatly from the vertical arrangements to restrict resale prices invalidated in *Albrecht* and *Kiefer-Stewart*, we should be hesitant to condemn them under a *per se* rule. *See United States v. Topco Associates, Inc.*, 405 U.S. 596, 607-08 (1972)("[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations of the Sherman Act"); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502,

6. Appellants argue that *American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1962), is controlling. We disagree. In *Hydrolevel*, the Supreme Court held that standard-setting organizations may be liable under the antitrust laws for the actions of their agents committed with apparent authority. In that case, committee members had conspired to restrain trade unreasonably through a misinterpretation of the Boiler and Pressure Vessel Code. As we have concluded here, however, neither the policy nor review committees have engaged in conduct that runs afoul of the antitrust laws. Hence, there is no illegal conduct that may be imputed to Blue Shield.

505 (2d Cir. 1982)(holding similar provider-insurer agreements valid under *per se* rule of vertical price-fixing). Moreover, if we were to extend *Albrecht* and *Kiefer-Stewart* to the facts in this case, there would have to be evidence of some collaboration or coercion to find an unlawful price-fixing agreement. Appellants cannot prove that Blue Shield collaborated with the participating dentists unless it can prevail in its claim that the dentists really control Blue Shield. As we have already shown, this claim fails.

Appellants also advance an economic coercion conspiracy theory, arguing that Blue Shield's UCR system and administrative practices pressure dentists economically to participate. Undisputed facts give no support to this theory as a matter of law. First, Blue Shield also pays for services rendered by non-participating dentists and determines its payment allowance for services uniformly — regardless of participation status. Moreover, its dental plan covers no more than 35% of the privately insured population and purchases less than 9% of the dental care in Pennsylvania. We conclude that there is no basis for an inference that dentists are coerced to participate with Blue Shield.

VI.

We turn now to appellants' contention that Blue Shield's UCR reimbursement system and related administrative practices, as well as its Dental Plus program, constitute an illegal boycott of non-participating dentists under § 1 of the Sherman Act. Dental Plus is a Blue Shield health maintenance organization program available to U.S. Steel employees at a certain plant that involves only participating dentists. Those dentists agree to provide all covered services to certain employee subscribers in return for a fixed fee per subscriber per month.

To establish proof of an illegal boycott under § 1, a plaintiff must show "concerted action with 'a purpose either to exclude a person or group from the market, or to accomplish some other anti-competitive objective, or both.' " *Malley-Duff & Associates, Inc. v. Crown Life Insurance Co.*, 734 F.2d 133, 140 (3d Cir. 1984)(quoting *DeFilippo v. Ford Motor Co.*, 516 F.2d 1313,

1318 (3d Cir.), *cert. denied*, 423 U.S. 912 (1975)). In the context of addressing appellants' *per se* price-fixing contention, we have already demonstrated that Blue Shield's actions in setting the UCR reimbursement fee and entering into the provider agreements were purely unilateral. Accordingly, the concerted action necessary for Blue Shield to succeed with its primary boycott claim is missing, and that claim must fail.

Appellants' Dental Plus claim must also fail for lack of concerted action because there is no evidence that Blue Shield conspired with any dentists to establish Dental Plus criteria that would exclude non-participating dentists. *See Klamath-Lake Pharmaceutical Ass'n. v. Klamath Medical Service Bureau*, 701 F.2d 1276, 1291 (9th Cir.)("[s]ome evidence of concerted activity directed at the alleged victims of the boycott must be offered for the case to survive summary judgment"), *cert. denied*, ____ U.S. ____, 104 S.Ct. 88 (1983). Thus, as with their price-fixing claims, appellants' boycott claims fail to establish a *per se* violation under § 1. We now turn to the monopolization claims asserted under § 2 of the Sherman Act.

VII.

Appellants argue that Blue Shield violated § 2 of the Sherman Act by attempting to monopolize and monopolizing the Pennsylvania market for the sale of prepaid dental care programs to group purchasers (Market I) and the Pennsylvania market for the quantity purchase of dental services (Market II).

Section 2 of the Sherman Act provides in pertinent part:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony . . . .

15 U.S.C. § 2. To establish the offense of monopolization under § 2, plaintiff must show: (1) the possession of monopoly power in the relevant geographic and product markets; and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of superior product,

business acumen or historic accident. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). The relevant geographic market is the area in which a potential buyer may rationally look for the goods or services he or she seeks, *id.* at 575-76; boundaries of a product market are detemined by the reasonable interchangeability of use or the cross-elasticity of demand, *SmithKline Corp. v. Eli Lilly & Co.*, 575 F.2d 1056, 1063 (3d Cir.), cert. denied, 439 U.S. 838 (1978); *see also Larry V. Muko, Inc. v. Southwestern Pennsylvania Building & Construction Trades Council*, 670 F.2d 421, 434 (3d Cir.), *cert. denied*, 459 U.S. 916 (1982). Monopoly power is generally defined as the power to control prices or to exclude competition, *United States v. E.I. duPont de Nemours & Co.*, 351 U.S. 377 (1956), and the size of market share is a primary determinant of whether monopoly power exists, *United States v. Aluminum Co. of America (Alcoa)*, 148 F.2d 416 (2d Cir. 1945).

To establish the offense of an attempt to monopolize under §2, plaintiff must show: (1) a specific intent to monopolize; and (2) the consequent dangerous probability of success within the relevant geographic and product markets. *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951); *Swift & Co. v. United States*, 196 U.S. 375 (1905). In proving specific intent, a mere intention to prevail over rivals or improve market position is insufficient. Even an intent to perform acts that can be objectively viewed as tending toward the acquisition of monopoly power is insufficient, unless it also appears that the acts were not "predominantly motivated by legitimate business aims." *Times Picayune Publishing Co. v. United States*, 345 U.S. 594, 627 (1953). Direct evidence of specific intent need not be shown; it may be inferred from predatory or exclusionary conduct. *Interstate Circuit, Inc. v. United States*, 306 U.S. 208 (1939); *United States v. Jerrold Electronics Corp.*, 187 F. Supp. 545, 567 (E.D. Pa. 1960), *aff'd*, 365 U.S. 567 (1961).

A.

The parties agree to define Market I as the market for the statewide sale of prepaid dental services in which Blue Shield competes with a commercial insurer, Delta Dental, and other

insurers. They further agree that Blue Shield's share of this market is 32-35%. The district court concluded that Blue Shield's market share was insufficient as a matter of law to establish monopolization of Market I, a conclusion appellants seem not to contest on appeal. We determine that this is entirely consistent with case law. *See Alcoa*, 148 F.2d at 424; *see also Twin City Sportservice, Inc. v. Charles O. Finley & Co.*, 512 F.2d 1264, 1274 (9th Cir. 1975). In addition, appellants' claim that Blue Shield attempted to monopolize Market I must fail as there is no evidence of specific intent. They point to the alleged §1 violations of price-fixing and boycott as proof of this intent, but we have already rejected those claims. Absent evidence of specific intent, we need not reach the question of whether Blue Shield's market share constitutes a "dangerous probability of success."

B.

The parties disagree over the definition of Market II. Appellants define Market II as the statewide market for the purchase of dental services in bulk pursuant to participating dentist agreements in which Blue Shield and Delta Dental are the only purchasers. They argue that in this market Blue Shield has a 91% market share. Blue Shield would define the statewide market more broadly. It contends that this market should include all purchasers of dental services in bulk, and not only Blue Shield and Delta Dental. Affidavits of chief executive officers of Blue Shield's competitors for dental insurance business and affidavits of 12 persons who arrange for the purchases of dental insurance plans for Pennsylvania businesses and companies support Blue Shield's contention that from the perspective of purchasers of dental care coverage, Blue Shield, Delta Dental, other health services corporations, and commercial carriers are all in direct competition with each other. The district court noted that appellants "present[ed] no conflicting evidence to establish a material fact in dispute." Mem. op. at 31, *reprinted in app.* at 3402. But for their part, appellants relied solely on an affidavit by Dr. Comanor, an economist, for their definition of Market II — an affidavit that expressed an opinion

based on factual assumptions for which appellants cited no support in the record and that was discredited by the district court.[7]

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7. The district court commented:

The Comanor affidavit refers to many factual assumptions for which plaintiffs have cited no support in the record: "In the approximately 13 years that prepaid dental care and dental insurance have existed in Pennsylvania, it has become apparent that the commercial insurers are unwilling to supply programs which involve direct provider contact." (No basis for these statements and conclusions is cited.) "Moreover, while Blue Shield offers a dental indemnity program (Penndental V), this product appears to have been relatively unsuccessful in Market I." (The plaintiffs have cited no evidence to permit the characterization of an objective on the part of Penndental V to compete in plaintiffs' Market I and a lack of success in that objective.) "On this basis, there appear to be factors which limit in Market I the degree of substitutability in production between prepaid service benefit dental programs and dental insurance or indemnity programs." (The language, "on this basis, there appears to be factors . . ." is an inadequate foundation for the conclusion which follows.) ". . . [V]arious large employers, as well as governmental bodies and unions themselves, desire only prepaid service benefit dental programs." (No factual basis for this statement is cited.) "For these groups, who are on the buying side of Market I, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be quite low." (This statement on its face is surmise.) "Fluctuations in price will not cause them to switch from a prepaid service benefit dental program to a dental indemnity program to the extent that they are committed, whether because of union pressures or some other reason, to provide fully prepaid dental care." (There is no factual basis cited for this statement. Further, it is a conditional statement and can not on its face support the conclusion that follows.) "For other purchasers, however, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be relatively high." (This statement on its face is surmise.) "In conclusion, the cross-elasticities of supply and demand in Market I suggest that it can be viewed as a market with two distinct sub-markets." (Considering the lack of a factual basis for the propositions leading to this conclusion and the tentative nature of this statement, the conclusion is not established for purposes of this motion.)

In establishing the existence of two markets of purchasers of dental services in Pennsylvania, Dr. Comanor views the relevant issue as "whether, in response to any possible price cuts by Blue Shield or Delta Dental, dentists will shift their output from the production of pre-paid dental care to individual dental care." If so, Dr. Comanor says, these two

To put Dr. Comanor's affidavit in proper perspective, reference must be made to expert testimony and especially to Rule 703, F.R. Evid., which provides:

> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to him at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

In *Merit Motors, Inc. v. Chrysler Corp.*, 569 F.2d 666 (D.C. Cir. 1977), the court, speaking through Judge J. Skelly Wright, emphasized that the factual predicate of an expert's opinion must find some support in the record. We agree with that court's decision and its reasoning:

> To hold that Rule 703 prevents a court from granting summary judgment against a party who relies solely on an expert's opinion that has no more basis in or out of the record than . . . theoretical speculations would seriously undermine the policies of Rule 56. We are unwilling to impose the fruitless expenses of litigation that would result from such a limitation on the power of a court to grant summary judgment.

569 F.2d at 673. We therefore agree with the district court's determination of this issue in two important respects: the Comanor affidavit did not raise an issue of material fact and, in discrediting this affidavit for lack of critical factual support, the court did not err in accepting the factual averments in Blue Shield's submissions that defined the boundaries of Market II.

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markets would effectively be one, but if not, there are really two separate and distinct markets. Dr. Comanor then concludes that whether "dentists will shift" depends upon whether dentists are at full capacity. If the dentist is not at full capacity, Dr. Comanor says, he is not likely to shift in response to price differences and there are therefore two markets. Dr. Comanor states that, "The fact that substantial excess capacity exists among Pennsylvania dentists suggests the finding of separate markets." The plaintiffs have cited no facts supporting the proposition that substantial excess capacity exists among Pennsylvania dentists.

Mem. op. at 28-30, *reprinted in* app. at 3399-401.

We also agree with the district court and conclude that appellants' monopoly argument, which hinged on their definition of Market II, must fall. Moreover, their argument that there was an attempt to monopolize must fail on the same grounds that it failed vis-a-vis Market I.

VIII.

This brings us to the summary judgment entered in behalf of Blue Shield on the class action claim asserted by the individual dentists. According to Rule 23(a), F.R. Civ. P., a class member cannot serve as a representative party on behalf of the entire class unless, *inter alia*, he or she will "fairly and adequately protect the interests of the class." Adequate representation depends on two factors: (1) the plaintiff's attorney must be qualified, experienced, and generally able to conduct the proposed litigation; and (2) the plaintiff must not have interests antagonistic to those of the class. *Eisen v. Carlisle & Jacqueline*, 391 F.2d 555, 562 (2d Cir. 1968). Where the district court appropriately applies the criteria of Rule 23(a). It has broad discretion in determining whether the action may be maintained as a class action, and it is subject to reversal only for an abuse of that discretion. *Katz v. Carte Blanche Corp.*, 496 F.2d 747, 757 (3d Cir.) (in banc), *cert. denied*, 419 U.S. 885 (1974).

In their class action counterclaim against Blue Shield, the individual dentists alleged two distinct subclasses of dentists: (1) a subclass of cooperating dentists, consisting of participating and non-participating dentists, who accept Blue Shield's allowances as full payment for their services; and (2) a subclass of non-cooperating dentists, all non-participating dentists, who bill Blue Shield subscribers for the balance between their current fees and Blue Shield's allowances. Of the four class plaintiffs, three are non-cooperating dentists and one, Dr. King, is a cooperating one. The subclass of cooperating dentists seeks damages in the amount of the difference between Blue Shield's allowances to them and the competitive price for their services. The district court refused to certify the subclass of cooperating dentists because (1) there are inherent conflicts between the

participating and non-participating dentists, and (2) as a non-participating dentist, Dr. King cannot fairly and adequately represent the participating members of the subclass. The district court properly applied Rule 23(a) to the undisputed facts of the case and determined that Dr. King's interests, as a non-participating dentist, were antagonistic to those of participating dentists who were also part of the subclass of cooperating dentists. We cannot say that the district court abused its discretion in finding him to be an inadequate class representative and refusing to certify the subclass on that basis.

IX.

We have considered the many contentions raised by appellants. We have concluded that the district court did not err as a matter of law or impermissibly resolve any disputed issue of fact in determining that Blue Shield did not engage in an illegal price-fixing conspiracy or boycott in violation of § 1 of the Sherman Act, in determining that Blue Shield did not attempt to monopolize or monopolize in violation of § 2 of the Sherman Act, and that the district court did not abuse its discretion in refusing to certify a subclass of cooperating dentists for treble damages purposes.

The judgment of the district court will be affirmed in all respects.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;	:	
Third-Party Plaintiffs	:	CIVIL ACTION
vs.	:	NO. 81-1187
MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA; d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY;	:	
Third-Party Defendants	:	

MEMORANDUM

The third-party defendants, Medical Service Association of Pennsylvania d/b/a Pennsylvania Blue Shield (hereinafter Blue Shield) and Donald S. Mayes, D.D.S., have filed a motion for summary judgment as to the claims asserted in the third amended third-party complaint (TATPC) of the third-party plaintiffs,[1] filed on November 30, 1982. This opinion addresses

1. The third-party plaintiffs are the Pennsylvania Dental Association (hereinafter PDA), Delaware County Dental Society, Erie County Dental Association, Inc., Harrisburg Area Dental Society, Luzerne County Dental Society, Montgomery-Bucks Dental Society, Odontological Society of Western Pennsylvania, Scranton Dental Society and York County Dental Society.

that motion.

The Commonwealth of Pennsylvania initiated this civil action on October 20, 1981, by filing a complaint against the Pennsylvania Dental Association (PDA) and a number of other dental associations, contending that these associations were violating antitrust laws, principally by encouraging dentists to terminate Blue Shield participating dentist agreements. The Associations filed answers to the complaint on or about November 9, 1981.

On November 17, 1981, the Associations filed the third-party complaint at issue here naming, *inter alia*, Pennsylvania Blue Shield and Donald S. Mayes, D.D.S. as third-party defendants. Blue Shield moved to dismiss the third-party complaint on December 7, 1981. On March 1, 1982, Blue Shield's motion was denied except with respect to paragraph 12 of the third-party complaint. This third-party complaint, like other pleadings in this case, has been amended a number of times.

On March 11, 1982, Blue Shield filed its answer and counterclaim to the third-party complaint naming the defendant Dental Associations and an additional Dental Association (Fifth District Dental Society) as counterclaim defendants and naming several individuals as additional defendants on the counterclaim.[2] Counterclaim defendants moved to dismiss Blue Shield's counterclaim, which motion was denied by order of July 30, 1982. On September 20, 1982, the counterclaim defendants filed a responsive pleading to Blue Shield's counterclaim, which included a class action counterclaim against Blue Shield and Dr. Mayes brought by PDA and three other Dental Associations.

On September 15, 1982, Blue Shield filed a motion for a preliminary injunction. On November 17, 1982, PDA filed a motion for a preliminary injunction. On December 30, 1982, both the motions of Blue Shield and of PDA for preliminary injunctions were denied.

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2. On March 12, 1982, Blue Shield commenced a separate action by complaint identical to its counterclaim which was consolidated with the case at bar.

On November 22, 1982, the Court granted a joint motion of the Commonwealth and the Dental Associations dismissing the initial complaint on the basis of a settlement agreement.

On January 25, 1983, the class plaintiffs filed a motion for class certification. On April 6, 1983, that motion was denied in part and granted in part, the Court denying class certification completely to one subclass and certifying another subclass for injunctive relief only. That order was appealed to the Third Circuit Court of Appeals on April 13, 1983. On April 26, 1983, Blue Shield and Dr. Mayes filed a motion to dismiss the appeal and on May 24, 1983, the appeal was dismissed.

PDA is a non-profit corporation under Pennsylvania law and is an association of dentists, most of whom are licensed to practice in Pennsylvania. TATPC, 3(A), page 3. The other third-party plaintiffs (hereinafter referred to as plaintiffs) similarly are non-profit corporations composed of dentists. TATPC, 3(B-I), pages 3-5. Blue Shield is a health service corporation formed and operating under the laws of Pennsylvania. 40 P.S. § 6301 *et seq*. Dr. Mayes is a vice president in charge of dental affairs of Blue Shield.

In the third-party complaint (hereinafter referred to as the complaint), the plaintiffs allege in Count I that "since at least 1974 and continuing to the present, Blue Shield, certain Pennsylvania dentists, and other co-conspirators have been and are involved in practices which vertically fix the price of prepaid dental care in the Commonwealth of Pennsylvania, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1." Blue Shield is alleged to fix the price of prepaid dental care vertically by use of "usual, customary and reasonable" (UCR) method of payment for services rendered by dentists to patients covered by a Blue Shield plan, and by coercing dentists who have not entered into a provider agreement with Blue Shield (pursuant to which dentists agree to accept Blue Shield's UCR-based reimbursement figure as payment in full for a given service to a patient) to charge no more than the UCR rate. TATPC, 9(A,B), pages 8-9. The plaintiffs allege that the defendants seek to coerce dentists who are not contractually obligated to charge no more than the UCR rate by having these dentists boycotted by their patients

and their potential patients. TATPC, 10, pages 9-10. They allege that a Blue Shield plan known as Dental PLUS, which provides for a covered patient in the plan to receive insurance coverage for dental services only if the patient utilizes participating dentists, constitutes a boycott in violation of 15 U.S.C. § 1.

Count II of the complaint is based upon 15 U.S.C. § 2 and alleges that Blue Shield is engaged in an attempt to monopolize the "statewide (i.e., Pennsylvania) market for the provision of dental care through third-party payers" and that there is a dangerous probability that Blue Shield will succeed in its attempt. In Count II, plaintiffs aver that 1,210,000 of the 3,280,000 citizens of Pennsylvania who are covered by prepaid dental care programs are covered by Blue Shield, and that almost all dentists provide services to Blue Shield covered patients. They further aver that most dentists have signed provider agreements with Blue Shield, and that other than Blue Shield's 1,210,000 insureds there are only 90,000 insureds in Pennsylvania who are covered by prepaid dental care programs through health service corporations. They contend that Blue Shield's practices and policies described in the first count of their complaint are prescribed or followed by Blue Shield in its effort to monopolize the statewide market for the provision of dental care through third-party payers and that this is in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

In Count III of their complaint, plaintiffs contend that Blue Shield has established an actual monopoly of a market in violation of 15 U.S.C. § 2. The relevant market, for purposes of Count III of plaintiffs' complaint, is described as, ". . . among others, the provision of prepaid dental care through health service corporations in Pennsylvania." TATPC, 33, page 18.

Count IV of the complaint charges the defendants with the state law torts of malicious abuse of civil process (for instigating the present litigation) and interference with business and contractual relationships between dentists and their patients.

Under Rule 56 of the Federal Rules of Civil Procedure, summary judgment is to be granted if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine

issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. Rule 56(e) provides that when a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of his pleadings, but his response, by affidavits or as otherwise provided by Rule 56, must set forth specific facts showing that there is a genuine issue for trial.

Rule 401.4 of the Rules of Court for the Middle District of Pennsylvania provides:

> 401.4 Motions for Summary Judgment. Upon any motion for summary judgment pursuant to Fed.R.Civ.P. 56, there shall be annexed to the motion a separate, short and concise statement of the material facts, in numbered paragraphs, as to which the moving party contends there is no genuine issue to be tried.
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> The papers opposing a motion for summary judgment shall include a separate, short and concise statement of the material facts, responding to the numbered paragraphs set forth in the statement required in the foregoing paragraph, as to which it is contended that there exists a genuine issue to be tried.
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> All material facts set forth in the statement required to be served by the moving party will be deemed to be admitted unless controverted by the statement required to be served by the opposing party.[3]

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3. Rule 401.4 obviously serves an important function in connection with any summary judgment motion. It permits the Court to determine efficiently and precisely which material facts are in dispute and which are not. The rule is particularly important in a complex case like this one which involves thousands of pages of depositions, documents and other materials arguably or potentially relevant to a summary judgment motion, and involving a plethora of contentions and claims most of which the plaintiffs have not articulated with precision and clarity. Appended as Exhibit N to their motion for summary judgment, defendants have filed a statement of material facts pursuant to Rule 401.4. Appended as Exhibit F to their belief in opposition to the motion, the plaintiffs have filed a counterstatement of material facts. A review of the statements submitted by defendants and plaintiffs reveals that plaintiffs have made no reasonable effort to agree to facts that are not in dispute, and instead

In analyzing the defendants' motion herein, the Court will rely upon those facts set forth in defendants' Rule 401.4 statement of facts and will also accept as true those specific facts asserted by plaintiffs to be material and in dispute if the plaintiffs have pointed with clarity to evidence acceptable under Rule 56 of the Federal Rules of Civil Procedure to establish such facts. The Court will not accept plaintiffs' conclusions as to those issues which are either ultimate issues of fact or legal issues in the absence of supporting specific facts, nor will the Court accept plaintiffs' general references to entire depositions or groups of depositions as establishing specific factual points.

Blue Shield is a non-profit "professional health service corporation" operating under a state regulatory act. 40 Pa.C.S. §§ 6301-6334. It has a thirty-two member board of directors. Sixteen are lay persons and sixteen are doctors (two of whom are dentists).

The Blue Shield practices, some or all of which are alleged by the plaintiffs to constitute or assist efforts to restrain trade, to monopolize or to boycott, are set forth at length in Exhibit N to defendants' motion, and the factual descriptions of the nature of the practice are essentially not disputed in Exhibit F to plaintiff's brief.

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have caused it to appear that facts are in dispute when they are not. The Court has examined these two sets of 87 numbered paragraphs submitted by defendants and plaintiffs. In most of its numbered paragraphs, Blue Shield has set forth a clearly stated fact or set of facts. In none of PDA's corresponding paragraphs is it indicated that Blue Shield's statement is undisputed, even though many of the paragraphs can not reasonably be disputed and even though PDA frequently, in other numbered paragraphs of its own, sets forth exactly the same facts. It is confusing and serves no worthwhile purpose for purposes of Rule 56 and Local Rule 401.4 for a party opposing summary judgment to refuse to acknowledge the existence of a fact advanced by a moving party if that fact can be established by the moving party and the opposing party has no evidence to refute it. If the asserted fact is not material, that is a matter for argument. If the asserted fact is material but the opposing party feels that additional facts relating to the same subject matter as the asserted fact are also material, the opposing party need only (by affidavits, argument, etc.) demonstrate the existence of disputed issues of material fact.

Blue Shield's share of the market consisting of all dental prepayment plans offered by all third-party payers in Pennsylvania is no greater than 40%. Entry into the Pennsylvania dental prepayment market by health and accident insurers is unrestricted. Blue Shield purchases, on behalf of its subscribers, less than 9% of all of the dental care that is purchased in Pennsylvania.

A dentist may choose to become a participating dentist. A participating dentist agrees with Blue Shield to accept the Blue Shield reimbursement for a particular dental procedure as full payment for that procedure. A participating dentist is paid directly by Blue Shield. When a non-participating dentist treats a patient who is a Blue Shield subscriber, Blue Shield does not pay the dentist directly, but instead pays the subscriber the amount of the Blue Shield reimbursement. The Blue Shield reimbursement may well be less than the fee charged by the non-participating dentist.

The Blue Shield reimbursement for a particular procedure is calculated by a procedure known as the "UCR" (usual, customary and reasonable) reimbursement system. The basic rule is that a dentist is reimbursed his "usual" charge for a given dental service. The dentist's usual charge is his most frequent charge for that service.[4] However, Blue Shield has calculated a "customary" charge for each dental service, that being the ninetieth percentile of all "usual" charges for all dentists throughout Pennsylvania who practice the same specialty. Blue Shield will not ordinarily reimburse a dentist more than the "customary" charge.[5] Blue Shield subscribers are assured by this

4. Blue Shield employs a formula to calculate the "usual" charge, pursuant to which the dentist's charges for a given service for the preceding calendar year and the first three months of the current calendar year are utilized. The "usual" charge is set at the seventy-fifth percentile of those charges. A listing of a dentist's usual charges for the range of services the dentist provides, so calculated, is known as the dentist's profile. Profiles are updated annually.

5. A dentist may be reimbursed more than the customary charge upon a demonstration of special circumstances relating to the particular service provided. We believe this to be the "reasonable" element of the UCR procedure.

system that their covered dental services will be paid for in full if they are treated by a participating dentist. A Blue Shield subscriber is a member of a group which has contracted with Blue Shield for a prepaid dental service plan for the members of the group.

Blue Shield's ordinary contract with participating dentists requires those dentists to permit Blue Shield to inspect their books and records. Blue Shield's stated reason for this practice is to insure that reported usual charges are accurate and that Blue Shield subscribers are not charged more for a given service than other dental patients.[6] If a participating dentist does not cooperate, his profile may be frozen. Blue Shield seeks to inspect the books and records of non-participating dentists, it says, for the same reasons.[7] When a non-participating dentist refuses such an inspection, Blue Shield frequently reacts by freezing that dentist's profile. When a dentist's profile is frozen, Blue Shield will not increase the amount of reimbursement for that dentist based upon newer and higher usual charges.

The two basic elements of a cause of action under Section 1 of the Sherman Act are, first, that the defendant(s) entered into a contract, combination or conspiracy and, second, that the contract, combination or conspiracy restrains trade. *Sitkin Smelting & Refining Co. v. FMC Corp.*, 575 F.2d 400 (3d Cir. 1978); *Medical Arts Pharmacy v. Blue Cross & Blue Shield*, 518 F.Supp. 1100 (D.Conn. 1981). The United States Supreme Court, early in the history of the Sherman Act, interpreted the Section 1 prohibition to require an analysis addressed to the reasonableness of a trade restraint, since virtually all contracts can be viewed to restrain trade in some respect. *Standard Oil Co. v. United States*, 221 U.S. 1 (1911). While some business

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6. One of the provisions of the standard agreement between Blue Shield and a participating dentist is that the dentist will not charge a Blue Shield subscriber more than a non-subscriber for the same service.

7. Non-participating dentists are "profiled" as to their usual charges the same as participating dentists by Blue Shield. Non-participating dentists have no agreement with Blue Shield, but Blue Shield will not reimburse a subscriber who is treated by a non-participating dentist more than that dentist's "usual" charge.

practices, such as horizontal price fixing among competitors,[8] have been judicially determined to be unreasonable *per se* "because of their pernicious effect on competition and lack of any redeeming virtue," *Northern Pacific Railway Co. v. United States*, 356 U.S. 1 (1958), the categories of *per se* antitrust violations are narrowly and carefully defined, and most allegations that particular business practices constitute antitrust violations are to be analyzed under the "rule of reason." Under this rule, the essential analysis is whether the practice in question is anticompetitive. *See, National Society of Professional Engineers v. United States*, 435 U.S. 679, 688 (1978).

> . . . not every agreement that has an impact on price, either vertically or horizontally, is a *per se* violation of the Sherman Act. *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 23, 99 S.Ct. 1551, 1564, 60 L.Ed.2d 1 (1979). For example, a contract for the sale of goods 'fixes' the price at which the goods are to be sold, but such a contract is not *per se* illegal, absent a showing of some adverse impact on competition. *Cf. United States v. Topco Associates Inc.*, 405 U.S. 596, 606, 92 S.Ct. 1126, 1133, 31 L.Ed. 2d 515 (1972); *Chicago Board of Trade v. United States*, 246 U.S. 231, 238, 38 S.Ct. 242, 243, 62 L.Ed. 683 (1918). The proper inquiry, thus, is not whether a particular agreement literally fixes a price, but whether the agreement is so 'plainly anticompetitive' and so very likely without 'redeeming virtue' that a court will apply the label '*per se* price fixing.' *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., supra*, 441 U.S., at 8-9, 99 S.Ct. at 1556-1557.

Medical Arts Pharmacy v. Blue Cross & Blue Shield, supra, 518 F.Supp. at 1106.

The analysis of the defendants' motion must proceed with the thought in mind that summary judgment in an antitrust case is to be sparingly granted, particularly if it appears that there are

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8. *See, Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 100 S.Ct. 1925, 64 L.Ed.2d 580 (1980).

factual questions presented as to the motive and intent of alleged conspirators, *Poller v. Columbia Broadcasting*, 368 U.S. 464 (1962). "Trial by affidavit is no substitute for trial by jury which so long has been the hallmark of 'even-handed justice'." *Poller, supra*, at 473. Yet the plaintiffs, who have urged that *Poller* prevents a grant of summary judgment here, have not asked for a jury trial. The same theories which would be presented to the Court at a non-jury trial are now before the Court in the context of the motion for summary judgment. Although credibility of witnesses would be an issue for determination only at trial, this does not affect the essential theory of plaintiffs' case. There are few credibility questions presented at all by the evidence and none that is material.

An antitrust case, like any case, is subject to analysis under F.R.C.P. 56 and summary judgment is appropriate if there are no material facts in dispute.[9] Here, a study of the statement of material facts submitted by the defendants pursuant to Rule 401.4 of the Local Rules, and of the plaintiffs' corresponding statement, reveals that there are no real disputes as to the nature of the practices and policies of Blue Shield to which the Dental Associations object. The areas of contention are the effects of those practices and policies, the motivation behind them, and the proper conduct of an analysis of the relevant market.

Naturally, the threshhold inquiry in any of PDA's Section 1 claims of vertical price fixing, boycott, and horizontal price fixing is whether Blue Shield has acted in concert with participating dentists to engage in these practices. This inquiry can best be addressed by examining PDA's claim that Blue Shield has engaged in horizontal price fixing.[10]

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9. ". . . [A]ntitrust litigation, if made immune from summary judgment, could become an anticompetitive activity itself . . . we should use summary dispositions to dispose of antitrust complaints that lack any significant supporting evidence." *Klamath-Lake Pharmaceutical Assn. v. Klamath Medical Service*, 1983-1 Trade Cases, ¶65,254, at page 69,507 (9th Cir. 1983).

10. Although not clearly expressed in the third amended third party complaint, the contention is that Blue Shield, as a "mere instrumentality" of certain dentists, has acted to maintain the price of dental care "at artificial

After extensive study of this case, it becomes clear that PDA's claim against Blue Shield really depends upon PDA's ability to prove its assertion that Blue Shield "is a mere instrumentality through which certain dentists and Donald S. Mayes, D.D.S. have conspired and do conspire in violation of the Sherman Act" and "is actually a mechanism through which a conspiracy or conspiracies of participating dentists is or are effected." Brief for plaintiffs, page 2. The initial and greatest hurdle in finding that the plaintiffs have established, for summary judgment purposes, a cognizable antitrust claim, is that they failed to clarify whether these dentists have conspired to raise dental services prices, lower them, stablize them, or affect them in some other way. If the conspiracy is to raise prices, PDA's grievance is not economic in nature, since there is no barrier preventing any dentist from becoming a participating dentist.[11] PDA has not explained the nature of its grievance.

A price restraint established by an agreement among competitiors in a service market, which tends to provide the same economic rewards to all practitioners regardless of their skill, experience, training, or willingness to employ innovative and difficult procedures in individual cases, violates the Sherman Act, even when the restraint is a maximum price and the competitors are physicians. *Arizona v. Maricopa County Medical Society*, 73 L.Ed.2d 48 (1982). There, a group of doctors agreed together upon maximum prices to charge for various medical services. Those doctors who participated in the plan agreed to accept no more than the maximum fee from patients who were insured under the doctors' plan. The Court held the plan to constiture a *per se* violation of the Sherman Act because it was a price-fixing scheme.

NOTES *(Continued)*

rates." Pre-trial order of third party plaintiffs at 38. We construe this, as does Blue Shield, as a claim of horizontal price fixing, pursuant to *Arizona v. Maricopa County Medical Society, infra*.

11. The fact that less than 9% of the dental care in Pennsylvania is purchased by Blue Shield on behalf of its subscribers looms large. The plaintiffs have made no showing or argument that the 91% of dental care for which there is not Blue Shield coverage will not seek out the lowest price for that dental care.

There are two principal differences between the facts of the present case and those in the *Maricopa County* case: (1) Here, there is no setting of a maximum fee, minimum fee or any fee at all. Both participating and non-participating dentists are free to independently arrive at and charge their own fee. (2) Here, there is no participation by the dentists in the setting of a maximum or minimum fee, first because there is no set fee and secondly because the UCR mechanism is established by Blue Shield which is not, like the Maricopa County Medical Society, an organization composed of practitioners.

The plaintiffs maintain that these differences are illusory. PDA claims that Blue Shield is an actuality an organization of providers or, in PDA's words, "a mechanism through which a conspiracy or conspiracies of participating providers is or are effected." PDA's argument in this regard is contradicted by the actual corporate and operational structure of Blue Shield and by the fallacies of the argument itself.[12] The fact that Blue Shield's thirty-two member board of directors is composed of 50% lay persons and has only two dentists upon it necessarily distinguishes Blue Shield structurally from ther Maricopa County Medical Society, which was composed entirely of participating providers. Only one-sixteenth of the persons responsible for making the decisions which PDA claims to be potentially and in fact anti-competitive are themselves competitors in the relevant market. The other fifteen-sixteenths of the board's members are themselves consumers of dental services whose natural interest would be in the success of Blue Shield as a health services insurer and who have not been shown to have any interest in the profitability of dentists' practices. To the extent that the plaintiffs contend, therefore, that the participating dentists and Blue

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12. It is important to note, since this is a motion for summary judgment, that it is not testimonial evidence that PDA relies upon to establish and advance its "conspiracy mechanism" argument. PDA does not point to conspiratorial conversations, the testimony of Blue Shield insiders or participating dentists to establish its conspiracy theory. To the extent that its theory is at all factually supported, it is on the basis of circumstantial evidence: the Blue Shield Board "rubber stamps" its committees' recommendations and the dental committees are composed of a majority of participating dentists.

Shield conspire to fix a higher price than the competitive market price, their assertion is not logical and is controverted by Blue Shield's structure. At the same time, it makes no sense to assert that the participating dentists conspire to fix prices that are lower than the competitive market prices. The inevitable conclusion, clearly supported by the material facts presented by this case, is that the dentists do not have control of Blue Shield.[13]

Plaintiffs also claim that the UCR mechanism does in effect set a fee, since a component part of the UCR mechanism is the state-wide "customary" fee for a particular dental service. However, the plaintiffs have presented no evidence that the "customary" element of Blue Shield's reimbursement formula has had any effect upon the fees charged either by participating or non-participating dentists in Pennsylvania. At most, they claim and could show that "UCR performance in Market II has approximated the ninety percent level each year since 1975." Brief for plaintiffs, page 16. By this, they seem to mean that the rate of reimbursement by Blue Shield for particular services to Blue Shield subscribers is, in the aggregate, approximately ninety percent of the aggregate usual charges of all reimbursed dentists for those services. That result is not the same as a maximum fee. the UCR reimbursement mechanism does not "serve to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individuals cases." Crediting PDA's theory fully, at most it can be said that a participating doctor, when treating a Blue Shield subscriber, may not realize the full benefit and value of his skill, experience, training and innovation to the extent that his fee exceeds the ninetieth percentile of statewide customary fees.

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13. Our attention has been directed by PDA in a supplemental brief, to the case of *St. Bernard General Hosp. v. Hosp. Service Ass'n of New Orleans, Inc.*, 1983-2 Trade Cases ¶65,565 (5th Cir. 1983), as illustrative of "effective" provider control and of other points. We believe, like *Maricopa*, *St. Bernard* is factually distinguishable from the case at bar since, in *St. Bernard*, each of the nine participating hospitals appointed two representatives to Blue Shield's thirty-one member board, the remaining thirteen members being elected by the eighteen members previously appointed.

This is necessarily a very limited impact upon price competition, applying as it does to only nine percent of the dental services performed statewide. As a matter of mathematical logic, it applies only to a very small percentage of those services, since only the charges of those dentists at the very upper end of the range of fees are so affected. In any event, the impact does not result from an agreement among providers, but rather from an agreement between the individual provider and Blue Shield.

Therefore, the decision in the *Maricopa County* case does not warrant a conclusion that there is an illegal price-fixing scheme in this case. Further, as Blue Shield has observed in its brief, this case is not factually similar to *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), where the practice of Blue Shield of Virginia was to reimburse services rendered by clinical psychologists only when those services were billed through a physician. There, the concentration of physicians (a majority)[14] on the Board of Blue Shield of Virginia, *when viewed in relationship to the practice in question*, led the Court to find the existence of an illegal horizontal arrangement. Here, the plaintiffs provided the Court with no such logical relationship between the structure of Blue Shield and any particular alleged anticompetitive results upon which to infer an antitrust violation. The plaintiffs generally claim to be aggrieved and aver that foul play is afoot, but they have failed to present facts and a cogent theory which demonstrate these claims. We conclude that this case is not governed by the *Maricopa County* case and that there is not a *per se* horizontal price-fixing violation.

Although we believe that the failure of proof of concerted action runs through PDA's other Section 1 claims, as well as the horizontal price fixing claim just discussed, we will examine each of these claims further. Provider agreements, such as those which exist between Blue Shield and participating dentists, have been scrutinized under the antitrust laws in large number of cases. In *Group Life & Health Insurance Co. v. Royal Drug*, 440

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14. Psychiatrists, who stood to gain by the practice, are physicians. Clinical psychologists are not.

U.S 205 (1979), the Supreme Court established a persepective of such agreements which is important in several respects to this case. The Court held that such agreements are not within the "business of insurance" exception to the Sherman Act and characterized them as "arrangements for the purchase of goods and services by [the insurer]." 440 U.S. at 214. In a number of other cases, courts have held such provider agreements to be lawful under federal antitrust law, and have done so in the context of motions for summary judgment. Many of these cases have involved facts very similar or analogous to those presented here. *See, Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F.Supp. 230 (N.D. Cal. 1981), *aff'd.*, 677 F.2d 47 (4th Cir.), *cert. den.*, 103 S.Ct. 376 (1982); *Quality Auto Body v. Allstate Insurance Co.*, 1980-2 Trade Cases ¶63,507 (N.D. Ill. 1980), *aff'd.*, 660 F.2d 1195 (7th Cir. 1981), *cert. den.*, 102 S.Ct. 1717 (1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn.*, 518 F.Supp. 1100 (D. Conn. 1981), *aff'd.*, 675 F.2d 502 (2nd Cir. 1982); *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia*, 498 F.Supp. 63 (E.D. Va. 1980); *Blue Cross and Blue Shield of Mich. v. Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cases ¶63,351 (E.D. Mich. 1980); *Davidowitz v. San Diego County Dental Society*, 1983-1 Trade Cases ¶65,231 (S.D. Cal. 1983). The view mandated by *Royal Drug*, that Blue Shield is the purchaser of dental services from the providers, is significant. Under the Sherman Act, "[t]he price fixing within the scope of the *per se* prohibition of section 1 is an agreement to fix prices to be charged in transactions with third parties, not between the contracting parties themselves." *Sitkin Smelting & Refining Co. v. F.M.C.*, 575 F.2d 440 (3rd Cir. 1978).[15] There is not, in the facts presented here, any evidence of any agreement to fix prices to be charged to third parties. To the extend that Blue Shield purchases dental services on behalf of groups of subscribers, there is no evidence of any agreements between Blue Shield and

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15. The contentions by the plaintiffs that there is a *per se* illegal *horizontal* price-fixing scheme is considered, *infra*, pp. 19-23 under the relevant case decisions.

providers as to Blue Shield's resale prices; i.e., Blue Shield's charges to subscribers for dental coverage.

In the absence of an agreement to fix prices to third parties and therefore of a *per se* vertical price-fixing violation, it must be considered whether the provider agreements and other practices of Blue Shield are *intended* to fix the prices of dental services for all dental service consumers, or are intended to affect quantity or quality of dental services, *see, Sitkin, supra; Royal Drug, supra;* or whether there is an anticompetitive effect of the agreements and practices. This analysis must be governed by the rule of reason.

Blue Shield asserts that its UCR program is not intended to and does not in fact set prices for dental services or otherwise restrain trade, in large part because the UCR reimbursement is based upon the fee actually charged by the dentist and because each dentist is free in any event to choose not to participate. PDA's argument that the UCR program does operate to set prices for dental services is not so simply stated. It contends that in the market in which dentists sell and either individuals or third-party payors buy dental services, Blue Shield is engaged in an effort to accumulate participating dentists by causing the fees of non-participating dentists to be greater than those of participating dentists for the same services. In turn, it contends, the prices charged by participating dentists are standardized or fixed by Blue Shield by the "customary" element of the UCR system, pursuant to which reimbursements for particular charges will not exceed the customary charge for that service. Further, PDA contends, dentists are coerced by various practices of Blue Shield to become and remain participating dentists even though the reimbursement for dental services is lower than the dentists' usual fees.

PDA principally appears to contend that Blue Shield's allegedly anticompetitive practices cause Blue Shield's reimbursements to undercut the ordinary charges of PDA's member dentists, and that Blue Shield is attempting "to suppress the

price of services purchased by it in Market II[16] as well as the supply of such services." (Brief for plaintiff, page 24). However, it also repeatedly and inconsistently asserts that Blue Shield has caused an artificial increase in the price of dental services by advising participating dentists to raise prices charged to Blue Shield to counteract the effect of the inherent discount resulting from the application of Blue Shield's UCR system. If it is true that Blue Shield advises participating dentists to raise prices to "beat" the UCR system, the only conceivable artificial or wrongful inflation of prices for dental services would be felt by the uninsured patients of participating dentists. PDA has advanced no reason, and none is imaginable, why these patients would not switch to other (presumably non-participating) dentists whose prices are not artificially inflated. Therefore, PDA has not demonstrated, in opposing the summary judgment motion, that Blue Shield's practices intentionally cause non-participating dentists to become participating dentists through the elevation of non-participating dentists' prices. Moreover, the case decisions have consistently held that provider agreements that require a participating provider to accept the UCR reimbursement rate as full reimbursement do not violate the antitrust laws. *Michigan State Podiatry Ass'n. v. Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cases ¶64,801 (E.D. Mich. 1982) *Blue Cross and Blue Shield of Michigan v. Michigan Ass'n. of Psychotherapy Clinics, 1980-2 Trade Cases ¶63,351 (E.D. Mich. 1980); Sausalito Pharmacy, supra; Davidowitz, supra; Michigan Ass'n of Psychotherapy Clinics v. Blue Cross and Blue Shield of Michigan*, 1982-83 Trade Cases ¶65,635 (Mich. Ct. Ap. 1982). "The failure to make more money, however, is simply not the kind of problem which the antitrust laws address." *Sausalito Pharmacy, supra*, 544 F.Supp. at 235. "The antitrust laws . . . protect competition, not competitors; and stiff competition is encouraged, not condemned." *Travelers Insurance Co. v. Blue Cross of Western*

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16. PDA's "Market II" is defined by it as the market in which "individual dental firms sell bulk dental services to be provided directly to patients/subscribers at no cost to the latter."

Pennsylvania, 481 F.2d 80, 84 (3d Cir.), *cert. den.*, 414 U.S. 1093 (1973). There is no significant difference presented in this case to warrant another result. PDA has not presented evidence which demonstrates that Blue Shield's practices restrain trade or eliminate competition in the market in which dentists sell, and individuals and insurers buy, dental services.

PDA's argument that Blue Shield also restrains trade by boycotting non-participating dentists and coercing or attempting to coerce dentists to become participating dentists by various practices is unconvincing. PDA contends that this occurs in part by reason of Blue Shield's refusal to make payment directly to non-participating dentists for services to Blue Shield subscribers, and by its refusal to notify these dentists that subscribers have been paid. Further, PDA alleges that Blue Shield publishes brochures "implying that non-participating dentists charge too much,"[17] publishes lists of participating dentists, and permits only participating dentists to become "excepted"[18]

17. The instances in PDA's brief in which it states conclusory facts rather than particular facts, with extremely general citation to supporting proof or no reference at all, are legion.

18. An "excepted" dentist is a dentist who is not routinely required by Blue Shield to submit diagnostic aides for Blue Shield's review in connection with claims for reimbursement for dental services. In 1979, Blue Shield began a practice of granting excepted dentist status only to participating dentists. It should be noted that the various practices of which complaint is made have been found acceptable by other courts. *See, e.g., Ratino v. Medical Service of District of Columbia*, 1981-1 Trade Cases, ¶64,144 (D. Md. 1981), (direct payment to patients of non-participating doctors only and informing subscribers of participating doctors' lower fees not a boycott); *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 417 F.Supp. 1104 (E.D. Pa. 1976) (publication of lists of participating doctors not a boycott); *Quality Auto Body v. Allstate Insurance Co.*, 1980-2 Trade Cases, ¶63,507 (N.D. Ill. 1980), *aff'd.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*. ___ U.S. ___, 102 S.Ct. 1717 (1982) (analog to excepted dentist classification considered reasonable business practice). We have been advised that *Ratino, supra* was reversed by the Fourth Circuit Court of Appeals on September 28, 1983. *See, Ratino v. M.S.D.C.*, 1983-2 Trade Cases ¶65,641. Although the reversal was based on grounds inapplicable here, the court in dicta did comment on the price fixing and other claims. Based on the thorough record before us, and the fact that this is a non-jury trial, we believe we have satisfied the analysis suggested in dicta by the court.

dentists.

Blue Shield's practice of not making payment directly to a non-participating dentist means simply that the non-participating dentist's payment relationship with his patient, who is a Blue Shield subscriber, is the same as his relationship with all of his other patients; that is, the dentist expects and presumably receives payment from the patient. PDA has not suggested what purpose notification to the non-participating dentist of the patient's receipt of a Blue Shield reimbursement check would serve. If it implies that dentists have collection problems, it lends support to Blue Shield's argument that to the extent that the Blue Shield UCR formula discounts some dentists' usual fees, it provides a corresponding benefit, certainty of collection. In any event, Blue Shield's practice is reasonable and pro-competitive. "Antitrust law does not condemn effective merchandising." *Human Resource Institute of Norfolk v. Blue Cross of Virginia*, 498 F.Supp. 63, at 67 (E.D. Va. 1980), citing *Travelers Insurance Co., supra*. The Court finds no evidence to support a boycott claim under Section 1 of the Sherman Act. Defendants are entitled to summary judgment as to this claim.

We turn to Counts II and III of the third-party complaint. Under Section 2 of the Sherman Act, which forms the basis for these counts of the plaintiffs' complaint, the plaintiffs would be required to establish at trial that Blue Shield possesses monoply power in a particular market and that such power was wilfully acquired or maintained, as distinguished from having developed as a result of a superior product, business acumen or historic accident. *United States v. Grinnell Corp.*, 384 U.S. 563, 570 (1966). To establish attempted monopolization under Section 2, plaintiffs' would need to prove a specific intent on Blue Shield's part to monopolize and a dangerous probability of success within a relevant product and geographic market. *United States v. Empire Gas Corp.*, 537 F.2d 296 (8th Cir. 1976), *cert. den.*, 429 U.S. 1122 (1977). Both offenses necessarily involve proof of a relevant market consisting of those products or services which compete with each other in the sense that they are reasonably interchangeable by consumers for the same purpose.

The plaintiffs' theory of monopolization and attempted monopolization on the part of the defendants focuses largely upon the market for the sale of prepaid dental services. As such, it is questionable whether the plaintiffs have standing to bring these Section 2 claims since it is other actual or putative sellers of prepaid dental services who would be harmed by the alleged monopolization. *See*, 15 U.S.C. §15. However, the plaintiffs contend that they are harmed, and defendants do not directly challenge plaintiffs' standing.

In attempting to establish their claim under Section 2 of the Sherman Act, the plaintiffs rely heavily upon the affidavit of William S. Comanor, Ph.D., appended to their brief as Exhibit B. The Comanor affidavit contains a series of conclusions concerning the existence of various markets, and the role played by Blue Shield and other entities and individuals in those markets. For purposes of the pending motion, Dr. Comanor's qualifications and competence to state the opinions contained in his affidavit will be assumed. The facts upon which he bases his opinion, however, may not be assumed to exist. Rule 56 of the Federal Rules of Civil Procedure requires a non-moving party to establish the existence of material facts by affidavit or otherwise. To the extent that the opinions stated by Dr. Comanor are based upon facts not established in a manner provided for under Rule 56, said opinions may not be treated as establishing a material factual dispute where one would not otherwise exist.

Dr. Comanor describes two principal markets in which he considers Blue Shield to operate. Market I is the market for the sale of prepaid dental care and of dental insurance. He views prepaid dental care to be so different from dental insurance, however, that he concludes that there are two relevant sub-markets within Market I, one for the sale of prepaid dental care and one for the sale of all other forms of dental insurance. The other market that he describes, Market II, is the market for the purchase of dental services. Here, again, he finds two sub-markets, one being the market for the purchase of dental care by an individual and the other being the market for the purchase of "bulk" dental care by prepaid dental care programs, the only two of which in Pennsylvania are Blue Shield and Delta

Dental.[19]

The finding that there are two separate markets in which dental services are bought and sold, coupled with the fact that Blue Shield and Delta Dental are the only two "buyers" of prepaid dental services, with Blue Shield being by far the larger of the two, permits Dr. Comanor to conclude that Blue Shield buys approximately ninety-one percent of all the commodities (prepaid dental services) sold in a particular market.

Dr. Comanor then concludes that Blue Shield has monopsony power as a buyer of prepaid dental services in Market II, which permits it to pay ten percent less for dental services provided to its subscribers than is paid for dental care provided to other persons. Monopsony power is exercised by a buyer who completely dominates a given market. Dr. Comanor is saying, in other words, that Blue Shield as a buyer in Market IIA pays less for dental care than individuals pay for dental care in Market II. Dr. Comanor does not explain how it is relevant to the existence of a monopoly that a buyer in one market pays less for a commodity than a buyer in another market pays for a different commodity.

The ultimate conclusion stated by Dr. Comanor is that "(1) Blue Shield's market share of about forty percent on the selling side of Market I understates its market power because of the high product differentiation which exists; (2) that Blue Shield has substantial monopsony power in Market II; and (3) it has exercised this power to the economic detriment of Pennsylvania dentists."

Defendants argue, in support of their motion for summary judgment as to Counts II and III of the complaint, that the plaintiffs have not adduced evidence which would permit us to define the relevant product market at issue more narrowly than the provision of prepaid dental care in Pennsylvania through all third-party payers. The Court is satisfied that this assertion is correct.

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19. Dr. Comanor views Blue Shield as a purchaser of dental services. He does not choose to view an insurance company as a purchaser of services because it pays for dental services at a set rate rather than on a UCR basis.

The Comanor affidavit refers to many factual assumptions for which plaintiffs have cited no support in the record: "In the approximately 13 years that prepaid dental care and dental insurance have existed in Pennsylvania, it has become apparent that the commercial insurers are unwilling to supply programs which involve direct provider contact." (No basis for these statements and conclusions is cited.) "Moreover, while Blue Shield offers a dental indemnity program (Penndental V), this product appears to have been relatively unsuccessful in Market I." (The plaintiffs have cited no evidence to permit the characterization of an objective on the part of Penndental V to compete in plaintiffs' Market I and a lack of success in that objective.) "On this basis, there appear to be factors which limit in Market I the degree of substitutability in production between prepaid service benefit dental programs and dental insurance or indemnity programs." (The language, "on this basis, there appears to be factors . . ." is an inadequate foundation for the conclusion which follows.) ". . . [V]arious large employers, as well as governmental bodies and unions themselves, desire only prepaid service benefit dental programs." (No factual basis for this statement is cited.) "For these groups, who are on the buying side of Market I, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be quite low." (This statement on its face is surmise.) "Fluctuations in price will not cause them to switch from a prepaid service benefit dental program to a dental indemnity program to the extent that they are committed, whether because of union pressures or some other reason, to provide fully prepaid dental care." (There is no factual basis cited for this statement. Further, it is a conditional statement and can not on its face support the conclusion that follows.) "For other purchasers, however, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be relatively high." (This statement on its face is surmise.) "In conclusion, the cross-elasticities of supply and demand in Market I suggest that it can be viewed as a market with two distinct sub-markets." (Considering the lack of a factual basis for the propositions leading to this conclusion

and the tentative nature of this statement, the conclusion is not established for purposes of this motion.)

In establishing the existence of two markets of purchasers of dental services in Pennsylvania, Dr. Comanor views the relevant issue as "whether, in response to any possible price cuts by Blue Shield or Delta Dental, dentists will shift their output from the production of pre-paid dental care to individual dental care." If so, Dr. Comanor says, these two markets would effectively be one, but if not, there are really two separate and distinct markets. Dr. Comanor then concludes that whether "dentists will shift" depends upon whether dentists are at full capacity. If the dentist is not at full capacity, Dr. Comanor says, he is not likely to shift in response to price differences and there are therefore two markets. Dr. Comanor states that, "The fact that substantial excess capacity exists among Pennsylvania dentists suggests the finding of separate markets." The plaintiffs have cited no facts supporting the proposition that substantial excess capacity exists among Pennsylvania dentists.

In fact, Dr. Comanor seeks to prove that there are two markets by viewing a history of participation by dentists with Blue Shield from 1975 to 1982 and by asserting that the number of participating dentists has generally increased despite the reduction of reimbursement rates by Blue Shield between 1975 and 1982 from ninety-eight percent to ninety percent.[20] He concludes that this finding can be explained by the substantial excess capacity in the production of dental services in Pennsylvania and the dentists' corresponding search for more business despite lower prices. The circular nature of Dr. Comanor's reasoning on this point is self-evident.[21]

Thus, the plaintiffs have alluded to no evidence to support the notion that Blue Shield, commercial insurance carriers and

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20. Of course, as already noted, these percentage figures represent averages. Blue Shield's reimbursement system compensates some dentists their full usual charge.

21. Besides relying on a fact that has not been shown, excess capacity, Dr. Comanor's concept that dentists will or would "shift" from insured to uninsured patients, or vice-versa, seems illogical, since it is doubtful that dentists would be in a position to concentrate on one group or the other.

other health service corporations do not compete for the business of purchasers of dental insurance. *See, United States v. E. I. du Pont de Nemours & Co.*, 351 U. S. 377 (1956). Competition is to be recognized where, in fact, competition exists. *Brown Shoe Co., Inc. v. United States*, 370 U. S. 294 (1962). The evidence cited by Blue Shield in its brief, including the deposition testimony of the chief executive officers of Blue Shield's competitors for dental insurance business, and the affidavits of twelve persons who arrange for purchases of dental insurance plans for Pennsylvania businesses and companies, establishes that from the perspective of purchasers of dental care coverage, Blue Shield and other health service corporations and commercial carriers are in direct competition. PDA presents no conflicting evidence to establish a material fact in dispute.[22] Moreover, Blue Shield's system of participating doctors and direct provider payment is not so obviously unique as to render other forms of dental plans non-competitive with Blue Shield from a potential customer's perspective. We conclude that to the extent

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22. PDA did file, on June 24, 1983 an affidavit of John G. Milakovic, pursuant to Rule 56(f) of the Federal Rules of Civil Procedure. In the affidavit Mr. Milakovic (who is one of PDA's attorneys) testified to his belief that cross-elasticity of supply and demand between prepaid service benefit dental programs and "commercial prepaid indemnity programs" was very low. To support these contentions, Mr. Milakovic offered to depose various witnesses whom he had been "unable to contact." Mr. Milakovic estimated that three weeks would be required to complete this process. We believe the affidavit should have been accompanied by a motion, to give Blue Shield an opportunity to respond (*See* Rule 7 of the Federal Rules of Civil Procedure). Further, we do not believe the extension sought is justified. Ample time was allowed for discovery, and the discovery period has expired long ago. We find PDA's inability to support this most fundamental aspect of its case, if only by affidavits, both inexplicable and unacceptable. In a related matter, PDA has moved to strike the affidavits submitted by Blue Shield to establish cross elasticity. Blue Shield has filed a motion to strike the motion and for counsel fees. Although the affidavits contain some conclusory and inadmissible statements, they also contain useful and relevant information which we will consider. We will not strike the affidavits or selected portions of them but will instead consider them for what they are worth. The court is familiar with the rules of evidence. PDA's motion to strike will be denied as will Blue Shield's motions to strike and for counsel fees.

that this case involves the market for the sale of prepaid dental coverage and an allegation by the plaintiffs of a Blue Shield monopoly in that market, said market is defined to include all prepaid service benefit dental programs and all dental insurance or indemnity programs.

Because Blue Shield's share of the market for the sale of dental coverage to consumers thereof in Pennsylvania is no greater than forty percent, it does not appear that a monopoly exists. *See, United States v. Aluminum Co. of America*, 148 F.2d 416 (2d Cir. 1945); *Twin City Sportservice, Inc. v. Charles O. Furley & Co., Inc.*, 512 F.2d 1264 (9th Cir. 1975); *Hiland Dairy, Inc. v. Krager Co.*, 402 F.2d 968, at 974 (8th Cir. 1968), *cert. den.*, 395 U.S. 961 (1969).[23] Furthermore, plaintiffs have not pointed to any real evidence which demonstrates that Blue Shield's forty percent market share permits it to have any control over the price of dental insurance or permits it to exclude competitors from the market, but instead have relied upon the highly speculative affidavit of Dr. Comanor, which itself is not based upon facts of record.

Blue Shield's market share is not sufficiently large to create a dangerous probability that it can succeed in monopolizing the market for dental insurance or prepaid dental care. *See, United States v. Empire Gas Corp.*, 537 F.2d 296 (8th Cir. 1976), *cert. den.*, 429 U.S. 1122 (1977); *Nifty Foods Corp. v. Great Atlantic & Pacific Tea Co., Inc.*, 614 F.2d 832, 841 (2d Cir. 1980); *Diamond International Corp. v. Walterhoefer*, 289 F.Supp. 550, 578 (D. Md. 1968); *Hoffman v. Delta Dental Plan of Minn.*,

23. The defendants have not pursued the proposition that self-insurance should be factored into the calculation of the percentage of the sales in the relevant market made by Blue Shield. However, considering the dynamics of collective bargaining and other factors which determine whether groups of persons will have dental insurance at all or may opt for higher wages or some other benefit instead, self-insurance may be a viable competitor of Blue Shield. From the perspective of the individual purchaser of a Blue Shield plan, moreover, a resort to self-insurance may readily be chosen as an alternative to prepaid coverage if the price of prepaid coverage becomes relatively high. If self-insurance is considered, then Blue Shield's market share in the relevant market is probably 9%, the percentage of dental services that are covered by Blue Shield insurance.

517 F.Supp. 564, 573 (D. Minn. 1981). Additionally, PDA has pointed to no evidence of acts, methods or plans devised or employed by Blue Shield to monopolize the market. It has not therefore pointed to evidence of a specific intent to monopolize on Blue Shield's part.

The plaintiffs seek to have us deny summary judgment and to permit the case to go to trial on the basis of a theory that is, at best, inherently inconsistent and incapable of clear, legal definition. In essence, they seek the opportunity to utilize the trial forum to pursue their case in search of its existence. A generous period of time has already been accorded plaintiffs for discovery in this case, and substantial discovery was pursued.[24] The inability of the plaintiffs at this juncture to set forth in direct and concrete terms the nature of their claims and the proof which supports them persuades us that further judicial resources should not be devoted to the plaintiffs' theories, and that this case is particularly appropriate for summary judgment.

The plaintiffs also have asserted that summary judgment should be refused because there are facts in dispute as to Blue Shield's motive and intent in establishing and pursuing the various practices to which the plaintiffs object. The absence of a clear and cogent theory of the nature of Blue Shield's antitrust infraction(s) defeats this assertion. The plaintiffs have failed to state clearly even the nature of the wrongful motive and intent

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24. Specifically, by order of October 21, 1981, discovery was ordered completed by February 1, 1982, and trial was listed for February 3, 1982. The third-party complaint was filed on November 17, 1981. On February 1, 1982, at the request of PDA, the discovery deadline was extended to November 15, 1982, and trial was rescheduled to begin December 3, 1982. On August 13, 1982, the court accepted a magistrate's report recommending that the discovery deadline be extended to February 28, 1983, with trial to commence on April 4, 1983. Subsequently, on January 18, 1983, the discovery deadline was extended to April 15, 1983, and the case was moved to the June, 1983 trial list. Although further requests for extension of the discovery deadline have been refused, trial of the case has been continued a number of times, most recently pending disposition of the instant motion.

that they would prove, and they have certainly failed to demonstrate that they have proof to support their conclusory allegations that Blue Shield and some or all participating dentists are conspiring to fix prices and boycott non-participating dentists.

There remains for consideration the plaintiffs' claim that Blue Shield's Dental PLUS program constitutes an illegal boycott against non-participating dentists and the plaintiffs' state law claims.

The Dental PLUS program is a dental care program provided by Blue Shield that is available to those employees of United States Steel Corporation who are employed at its Fairless Hills plant, and who elect such coverage. Under Dental PLUS, a dental office which has agreed to participate in the program provides all covered dental services to the subscribers in return for a fixed fee per subscriber per month. This arrangement is variously described as a "capitation" or "health maintenance organization" concept. The employees of the steel plant are free to accept or reject participating in the program, and to date sixteen percent of the employees have elected to participate. The others receive ordinary Blue Shield UCR coverage, already considered herein. Dental PLUS providers must be Blue Shield participating dentists.

Plaintiffs argue that the Dental PLUS program amounts to an illegal boycott of those dentists who do not participate in the program. Defendants in turn reply that there is not an actionable boycott of non-participating dentists since there is no element of coercion present with Dental PLUS and that, in any event, Dental PLUS is immune from the application of the antitrust laws because it constitutes state action. There appear to be no material facts in dispute concerning the Dental PLUS program and the merits of the plaintiffs' claim may therefore be decided under F.R.C.P. 56 as a matter of law. In view of the very limited presence of the Dental PLUS program in Pennsylvania currently, it is not conceivable that it operates in any significant way as a boycott since it affects at most, the economic interests of a small number of Pennsylvania dentists. A more meaningful evaluation of the effects of Dental PLUS could be

accomplished if and when the program becomes more widespread. The Court concludes, as did the Ninth Circuit Court of Appeals in *Klamath Lake Pharmaceutical Association v. Klamath Medical Service Bureau*, 1983-1 Trade Cases, ¶65,254 (9th Cir. 1983), that the program, at least as it presently exists in Pennsylvania, represents merely the simple exercise by Blue Shield of its freedom of contract. A solitary contract involving sixteen percent of the employees of one steel plant cannot reasonably be viewed as a boycott of all other dentists in Pennsylvania such as is prohibited by the antitrust laws. The defendants contend that, in any event, Dental PLUS constitutes state action which is exempt from the federal antitrust laws because capitation reimbursement plans such as Dental PLUS are specifically authorized and encouraged by Pennsylvania law and the Pennsylvania Departments of Health and Insurance. Because the defendants are entitled to summary judgment as to the Dental PLUS program at the Fairless Hills steel plant on the grounds that it does not constitute a boycott on the facts presented here, however, the state action exception issue need not be reached.

Count IV of the plaintiffs' complaint, which alleges causes of action under state tort principles, will be dismissed. Jurisdiction for these state claims arises solely because they are pendent to the federal antitrust claims. Plaintiffs have made no showing of exceptional circumstances warranting our exercise of pendent jurisdiction. *See, Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc., supra.*[25]

The class action counterclaim against Blue Shield and Dr. Mayes, filed on September 20, 1982, as a part of the reply of PDA and others to the third-party counterclaim of Blue Shield, must be considered in connection with our decision to grant summary judgment in favor of the third-party defendants upon the third-party complaint. The claims made in the class action counterclaim are the same as the claims in the first three counts

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25. Although Blue Shield filed a motion for summary judgment on these claims, the motion was not timely since it was filed on the day of oral argument on the pending summary judgment motion.

of the third-party complaint. However, there are parties in the class action counterclaim (the members of the certified class) in addition to those in the third-party complaint. Moreover, Blue Shield and Dr. Mayes have not stated that its present motion for summary judgment is made as to the class action counterclaim as well as to the third-party complaint. It would, however, serve no valid purpose for the Court to act upon the motion for summary judgment with respect only to the third-party complaint and not with respect to the class action counterclaim when precisely the same issues are involved in both. Summary judgment therefore will be granted in favor of Blue Shield and Dr. Mayes upon both the third-party complaint and the class action counterclaim.

IT WILL BE SO ORDERED.

William W. Caldwell
United States District Judge

Date: October 28, 1983

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;	:	
Third-Party Plaintiffs	:	CIVIL ACTION NO. 81-1187
vs.	:	
MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA; d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY;	:	
Third-Party Defendants	:	

ORDER

AND NOW, this 28th day of October, 1983, it is hereby ORDERED that third-party defendants' motion for summary judgment is granted as to Counts I, II and III of the third-party complaint, and judgment is hereby entered in favor of third-party defendants on these counts and against third-party plaintiffs. Count IV of the third-party complaint is dismissed. Summary judgment is hereby entered in favor of the third-party defendants in the class action counterclaim and against the third-party plaintiffs. The motion of third-party plaintiffs to strike affidavits attached as exhibits B through M of the motion

for summary judgment is denied. Third-party defendants' motion to strike the aforesaid third-party plaintiffs' motion to strike and for counsel fees is denied.

This case will be placed on the April, 1984 trial list for trial of the remaining issues. A scheduling order will follow.

William W. Caldwell
United States District Judge

APPENDIX G

CONSTITUTIONAL PROVISIONS, STATUTES, AND RULES

This case involves petitioning under the first amendment, an alleged conspiracy under Section One of the Sherman Act, and claims for damages and injunctive relief under Sections Four and Sixteen of the Clayton Act. The Third Circuit's decision involves all of these provisions, and also raises serious due process and Fed.R.Civ.P. 56 questions. All of the pertinent provisions are reprinted in Appendix F.

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

U.S. CONST. amend. I.

> No person shall . . . be deprived of life, liberty, or property, without due process of law. . . .

U.S. CONST. amend. V.

> Every contract, combination . . . or conspiracy in restraint of trade or commerce among the several States . . . is hereby declared to be illegal. . . .

Sherman Act, Section 1, 15 U.S.C. §1.

> Except as provided in subsection (b) of this section, any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee. . . .

Clayton Act, Section 4, 15 U.S.C. §15(a).

> Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief in any court of the United States having jurisdiction over the parties against threatened loss or damage by a violation of the antitrust laws, including sections 13, 14, 18 and 19 of this title, when and under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damage is granted by courts of equity. . . .

Clayton Act, Section 16, 15 U.S.C. §26.

> A party against whom a claim, counterclaim, or cross-claim is asserted or a declaratory judgment is sought may, at any time, move with or without supporting affidavits for a summary judgment in his favor as to all or any part thereof.

Fed.R.Civ.P. 56(b).

> The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. . . .

Fed.R.Civ.P. 56(c).